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MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS

A REPORT

PREPARED BY THE

CONGRESSIONAL RESEARCH SERVICE

FOR THE USE OF THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON ENERGY AND COMMERCE

U.S. HOUSE OF REPRESENTATIVES

NOVEMBER 1988

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PHONE (202) 225-4952

October 14, 1988

Honorable John D. Dingell
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I am enclosing for your review a report entitled "The Medicaid Source Book," which was prepared at the request of the Subcommittee on Health and the Environment by the Education and Public Welfare Division of the Congressional Research Service.

As you know, the Subcommmittee on Health and the Environment has jurisdiction over Medicaid, our nation's largest source of health care financing for the poor. This year, according to the Congressional Budget Office, the Federal government alone will spend an estimated $30.5 billion to purchase basic health care services on behalf of some 23 million low-income people. The three principal populations served by the Medicaid program are among the most vulnerable in our society: poor families with dependent children; poor elderly, including those at risk of nursing home care; and the mentally retarded.

Despite Medicaid's scope and complexity, there has to this date been no satisfactory single source to which Members could refer for up-to-date information about the program. To fill this gap, the Subcommittee requested the Congressional Research Service to develop an in-depth description of the program, including eligibility and coverage policy, reimbursement practices, expenditure trends, financing, and administration. The Subcommittee majority staff, with the assistance of the House Office of Legislative Counsel, has prepared two addenda: a description of Medicaid changes enacted by the 100th Congress shortly after the submission of the CRS report; and an index to the Medicaid statute designed to assist readers in locating selected provisions.

In my view, CRS has produced a well-documented, comprehensive source book that provides a wealth of current information about the Medicaid program, including a substantial amount of original data analysis. It will be of great value not only to Members, but also to program administrators, policy analysts, and others. This document merits widespread distribution, and I therefore request that it be published as a Committee print.

With every best wish, I am

Sincerely,

Henry A. Waxman
Chairman

LETTER OF SUBMITTAL

Congressional Research Service
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Washington, D.C. 20540

September 29, 1988

Mr. Henry A. Waxman, Chairman
Subcommittee on Health and the Environment
Committee on Energy and Commerce
U.S. House of Representatives
Washington D.C. 20515

Dear Mr. Chairman:

I am pleased to submit to you this report, Medicaid Source Book: Background Data and Analysis, in response to your request for a special study exploring the many-faceted dimensions of Medicaid. As you well know, the Medicaid program is highly complex in its eligibility criteria, services offered, and impact on certain demographic groups. This complexity raises innumerable policy questions of legislative interest.

The highest priority of the analytical team assigned to this project was to produce a comprehensive document that would help the requesting Committee and Congress understand the details of the Medicaid program, and potential sources of future program pressures.

The report provides a description of the current program, an analysis of the impact of the program on selected populations, the exploration of special topics like Medicaid and AIDs, and the program's use of alternative health-related delivery mechanisms.

We hope this report will prove useful to members of your Committee and of Congress in their deliberations and consideration of legislation affecting the program.

Sincerely,

Joseph E. Ross
Director

PREFACE

Title XIX of the Social Security Act provides for a program of medical assistance for certain persons with low income, Medicaid. This means-tested entitlement program became part of Federal law in 1965. It succeeded earlier cash welfare-linked programs, perhaps the most notable of these being the Kerr-Mills program that provided medical assistance for the aged. Medicaid acts as a vendor payment program; that is, it makes direct payments to medical providers for their services to Medicaid eligible persons. It is the largest health program providing medical assistance for the poor, but contrary to popular belief, Medicaid is not intended to provide medical assistance to all of the poor. A person's income is only one criteria used in determining eligibility. Of equal importance, a person must belong to certain designated groups. These groups includes children in single parent families, the aged, the blind and the disabled. Medicaid eligibility policy is highly complex.

Medicaid is financed by both Federal and State funds. Federal contributions to each State are based on the size of a State's spending on covered medical services, and a matching formula. Each State designs and administers its own program under the general oversight of the Health Care Financing Administration (HCFA), Department of Health and Human Services (HHS). In fiscal year 1987, Federal and State Medicaid spending equalled $49.4 billion; approximately 23.3 million persons received care. There is a substantial amount of State variation in the number of individuals covered, the types of services offered, and the amount of money spent on these services.

Over the past 23 years the Medicaid program has gone through many changes. Recent legislative changes have broadened its coverage of the low income population; the program's strong ties to the cash-welfare system have been weakened—but not broken. The limitation of program coverage to medical services has been challenged. Recently, through the use of alternative delivery options, in some States the scope of program services has expanded to include some nontraditional, nonmedical service alternatives. In addition, Medicaid has responded to a number of demographic and epidemiological changes in our population. The program plays a major role in providing long-term care for an aging population. It has emerged as an important source of coverage for persons with acquired immunodeficiency syndrome (AIDS). It is directly affected by the plight of the mentally ill and the homeless. Furthermore, the program has become a major funding source for medical and health-related services for the mentally retarded.

I. PURPOSE AND SCOPE OF STUDY

Given Medicaid's broad scope and State to State variability, people ask numerous questions about how it actually works and who is covered. The purpose of this report is to help answer some of these more frequently asked questions. Some of these questions include:

- Who is eligible for the Medicaid program?
- What services are covered?
- How is the program administered? What is the program's method of reimbursement? How is the program financed?
- Does the program cover most of the poor? Is the program a major provider of services for the aged? Are many children covered by the program? How are Medicaid services provided to special populations like AIDS patients, the mentally ill and individuals with mental retardation?
- What are the most recent legislative changes in the program?
- What type of providers participate in the program? Has the interest in containing cost affected where Medicaid services are provided?
- Do beneficiaries have alternatives to nursing homes, hospitals, and private physicians offices for their care? What are these alternative delivery settings and how widespread is their use?
- How does the program constrain the cost of care, but assure quality of care?

In order to answer these and other questions this report is organized into three parts:

The first part (Chapters I through X) describes how the Medicaid program works. Topics covered in this section include: eligibility, services covered, how Medicaid reimbursement works, how the program is administered, how the program is financed, and a compendium of recent legislative changes (changes since 1980) that have affected the program.

The report's second part (Appendix A to Appendix E) describes how Medicaid affects specific demographic groups. Appendix A provides estimates of the Medicaid coverage rate of the poor, Appendix B details the health status of children and how Medicaid affects that status, and Appendix C explores the dual role Medicaid plays for the aged—acting as an important payor of long term care services for many of the aged, but also acting as a source of payment for many health services for the aged poor. Appendix D describes the health needs of the mentally retarded and how Medicaid has become a major provider of services for this group. Appendix E provides a brief overview of Medicaid's role in long-term care institutions for those with mental disease.

Finally, the third part of the report explores three important topics: Appendix F describes how Medicaid is attempting to contain costs and provide adequate access to health services through managed care. Appendix G provides estimates of the participation of physicians, inpatient hospitals and nursing homes in the Medicaid program and explores some of the possible reasons for the participation rates. Appendix H details the possible impact of the AIDS epidemic on the Medicaid program.

II. METHODS OF STUDY

To carry out this study the Congressional Research Service relied on a number of different data sources. Program statistics were analyzed based on data from the Health Care Financing Administration's Medicaid program statistics data tapes for fiscal years 1975 to 1986. In addition estimates of Medicaid coverage for the poor, children and the aged relied on data from the March 1987 Current Population Survey annual supplement of income. This supplement provides information on an individual's income and selected program participation for the previous calendar year (1986). Since this Bureau of Census data provides information on the noninstitutionalized population, analyses of the nursing home population contained in this report relied on other data sources. The most often used source for this information was the 1985 National Nursing Home survey conducted by the National Center for Health Statistics.

Each of these data sources had its own strengths and weaknesses. Using these rather distinct data sources the study confirms many previous findings about the Medicaid program, yields new insights, and raises several questions for further analysis.

III. ACKNOWLEDGEMENTS

A team of CRS analysts worked together and agreed on the scope and methods to be used in describing and analyzing the Medicaid program. Individual members of the team are responsible for different chapters of the report. All members of the team participated in intensive review of all the draft chapters of the report. The project was directed by Richard Rimkunas. The principal authors of the report are: Jennfier O'Sullivan (Overview, Eligibility, Services, Financing, and Recent Legislative Changes); Mark Merlis (Reimbursement, Alternative Delivery Options, Administration, Medicaid and the Mentally Ill, Managed Care, Medicaid and Health Care Providers, Medicaid and AIDs); Richard Rimkunas (Overview, Program Statistics, Medicaid and the Poor); Richard Price (Medicaid and the Elderly); Mary Smith (Medicaid, the Mentally Retarded and ICF/MR Services); Joseph Cislowski (Medicaid and Children); Keith Hurt and Shivaun Nurre (Selected Bibliography). The author of each chapter is noted in its introduction. Research Assistance was provided by Keith Hurt and Shivaun Nurre. All of the authors relied on the considerable experience and expertise about Medicaid that Mark Merlis and Jennifer O'Sullivan brought to the research team.

Richard Rimkunas provided most of the estimates contained in the report, based on analyses of HCFA forms 2082, the Current Population Survey, and the National Nursing Home Survey. Keith Hurt provided invaluable support in the analysis of this information.

Flora Dean directed secretarial production of the report. The text and tables were typed by a patient and reliable team: Phillip Brogsdale, Tracy Byrd, Denise Carter, Flora Dean, Dolores Schofield and Martha Williams.

Helpful comments on earlier drafts of the reports were made by: Ken Cahill, Gene Falk, Janet Kline, Sharon House, and Carmen Solomon of the Education and Public Welfare division of CRS.

The authors would like to acknowledge the help of the State Medicaid Information Center, National Governor's Association. The Center provided invaluable information on State Medicaid policies and practices. Numerous officials from the Health Care Financing Administration cooperated with our research effort by providing program data. Don Muse of the Congressional Budget Office provided the cost estimates used in Chapter VIII,"Recent Legislative Changes."

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CHAPTER I. MEDICAID: AN OVERVIEW [1]

I. INTRODUCTION

A. Overview

Medicaid is a Federal-State entitlement program that pays for medical services in behalf of certain groups of low-income persons. Each State designs and administers its own Medicaid program, setting eligibility and coverage standards within broad Federal guidelines. As a result, there is substantial variation among the States in terms of persons covered, types and scope of benefits offered, and amounts of payments for services.

The Department of Health and Human Services projects that in fiscal year 1988, the program will pay for medical services for 24.2 million persons at a total cost of $55.2 billion; of this amount, $30.7 billion will be Federal funds and $24.5 billion State funds. (See figure I–1.) Beneficiaries of the program will include 3.5 million persons age 65 or over, 3.4 million disabled or blind, 10.4 million dependent children,[2] 6.2 million adults in families with dependent children, and 1.4 million other persons (primarily children who do not meet the statutory definition of dependent child). (See figure I–2.)

The distribution of program spending differs from the distribution of the population served. In 1986, Medicaid payments for services totalled $41 billion. The aged accounted for 36.8 percent of payments, the blind and disabled 36.4 percent, dependent children 12.5 percent, adults in families with dependent children 11.9 percent and other persons 2.4 percent. (See figure I–3.)

Medicaid is a means-tested entitlement program. This means that certain groups of persons (i.e. the aged, blind, disabled, members of families with dependent children, and certain other children and pregnant women) qualify for coverage if their incomes and resources are sufficiently low. Persons who meet these categorical, income and resource tests are entitled to have payment made by the State for covered, medically necessary services furnished by qualified providers. States are entitled to have matching payments made by the Federal Government for outlays for covered services. There is no Federal limit on payments; allowable State claims are matched according to a statutory formula. The program was enacted as part of the Social Security Amendments of 1965—the same legislation that established the Medicare program. The Medicaid provisions were essentially a modification and expansion of several

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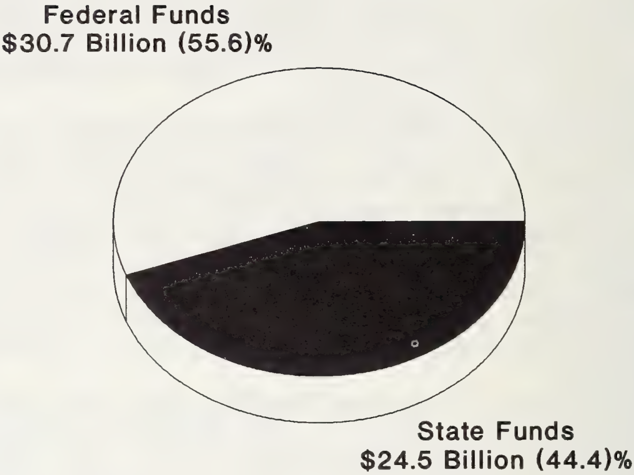
[1] Jennifer O'Sullivan is the author of part I of this chapter, Richard Rimkunas is the author of part II.

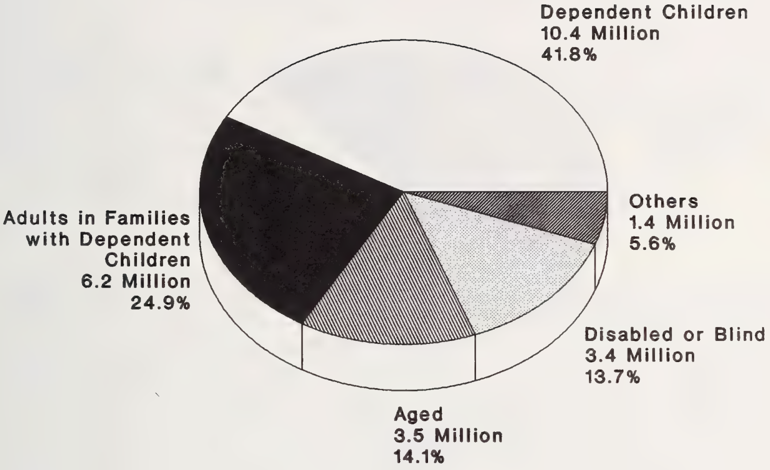
[2] Dependent children are those who are in a family where one parent is absent, incapacitated, or (in some States) unemployed.

Figure I-1
Estimated Medicaid Spending, FY 1988
Federal and State Share



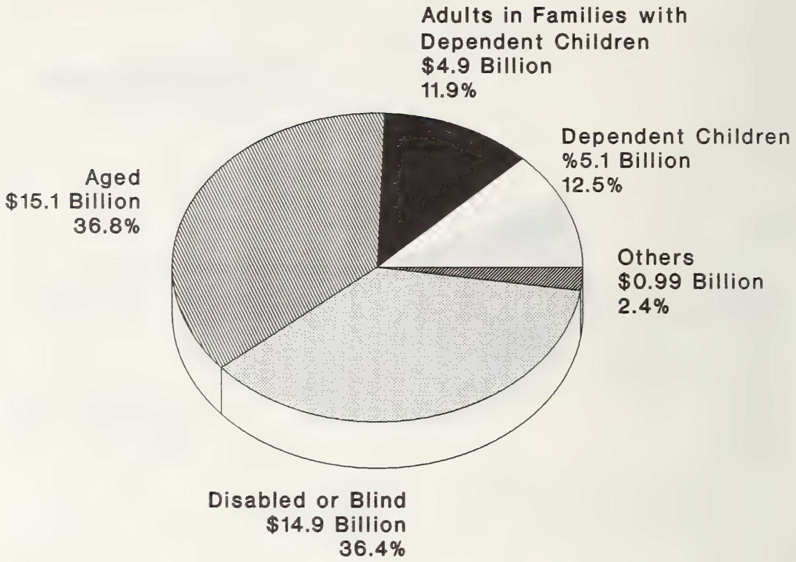
Source: HCFA estimates.

Figure I-2
Medicaid Beneficiaries, by Eligibility Status, FY 1988



Source: HCFA estimates.

Figure I-3
Medicaid Payments by Eligibility Status, FY 1986



Source: HCFA form 2082.

earlier programs (including the Kerr-Mills program enacted in 1960) which provided medical payments for certain needy individuals. These earlier programs were directly linked to cash welfare programs. That linkage also formed the basis for eligibility for the new Medicaid program.

The welfare program linkage, coupled with individual State decisions in structuring their programs, has produced a program which offers coverage to less than half of the population with incomes below the Federal poverty line. Approximately 41 percent of the poor were covered by Medicaid in 1986; the percentage varied by age with coverage extended to 52 percent of poor children, 34 percent of poor working age adults, and 31 percent of the poor aged.[3] The likelihood of Medicaid coverage is associated with an individual's degree of poverty. Close to 6 out of 10 people in families with incomes (excluding cash assistance payments) that are less than half of the poverty threshold are covered by Medicaid. Less than one out of five people with incomes between 75 and 100 percent of poverty are covered. Furthermore, Medicaid coverage is not limited to the poor; some individuals (primarily nursing home residents) with incomes above the poverty threshold are able to establish eligibility if they have high medical costs.

B. FEDERAL REQUIREMENTS AND STATE OPTIONS

1. ELIGIBILITY

Since Medicaid's enactment, eligibility has generally been linked to actual or potential receipt of cash assistance under a welfare program (i.e. the Supplemental Security Income program or the Aid to Families with Dependent Children program). Thus eligible persons have to meet the cash assistance program's definition of age, blindness, disability, or membership in a family with dependent children. The link between Medicaid and welfare programs has several effects on program eligibility. First, persons who do not fall into one of the welfare categories generally are not eligible for Medicaid, regardless of their income level. Second, persons who fall into one of the coverage groups must also meet specified income and resource criteria which vary by State. Automatic coverage is generally limited to persons with incomes and resources which are sufficiently low to qualify them for welfare payments. These levels are generally, and in some cases considerably, lower than the poverty line.

While the link to cash assistance has been the primary way to establish eligibility, States have been able to extend coverage to children who meet the income and resources requirements but do not meet the definition of dependency. More recently Congress has taken a number of steps to enable States to provide coverage to certain low-income groups not otherwise eligible for Medicaid coverage.

Federal requirements for program coverage are not the only set of factors determining Medicaid eligibility. A second set of factors are the decisions made on the part of individual States. First, decisions regarding where States set income levels for cash assistance programs will also affect the size of their Medicaid programs. In fact the cost consequences may be greater for Medicaid than the cash assistance programs. Second, within Federal guidelines, States have considerable leeway in establishing Medicaid eligibility criteria. Thus individuals in similar situations may be automatically eligible for coverage in one State, be required to assume a certain portion of their medical expenses before they can gain coverage in a second State and not be eligible at all in a third State. All States do, however, provide some mechanism whereby some of their nursing home population, which would not otherwise be eligible for coverage may be eligible for protection; frequently eligibility for this group begins only after they have spent a portion of their incomes and/or resources on medical care.

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[3] This data is based on the Current Population Survey. Since the sample does not include institutionalized individuals, the percentage rate for the aged is probably understated.

2. SERVICES

State decisions are not limited to eligibility determinations. Within Federal guidelines, each State defines its own benefit package. States are required to provide a defined package of services to a majority of the Medicaid population. These so-called "mandatory services" include hospital and physicians' services and care in a skilled nursing facility (SNF). States may also offer any of a broad range of so-called "optional services" including prescribed drugs, eyeglasses, services in an intermediate care facility (ICF) and services in an intermediate care facility for the mentally retarded (ICF/MR). States may place limits on the coverage of all services. For example, they may place limits on the number of covered hospital days or the number of covered physicians' visits. Thus there is considerable variation among the States in the types of services covered and the amount of care provided under each service category.

3. PAYMENTS FOR SERVICES

States have considerable discretion to develop their own method and standards for paying for Medicaid services. Different methods are used for different types of services. Most States have moved to "prospective" payment systems for hospital and nursing home (SNF and ICF) services. Under these systems, the amount of payment for a defined unit of service (such as full treatment of a hospital case or a day of care in a nursing home) is determined in advance. For services of physicians or other individual practitioners, payments are usually the lesser of the actual charge or a maximum amount set by the State. A variety of payment approaches is used for other services; Federal law establishes specific payment rules for only a few of them.

While States may use similar approaches for payment for a particular service category, the specifics may vary considerably. Federal regulations require States to develop payment rates which are sufficient to attract enough providers so that covered services will be available to Medicaid beneficiaries to the same extent they are to the general population.

4. PROVIDERS

Variations exist in provider acceptance of the Medicaid program. Beneficiaries have "freedom of choice" in obtaining services from any qualified provider that undertakes to provide the service. However, providers may or may not decide to participate in the program. If they do so, they must agree to accept Medicaid's payment as payment in full for covered services; they can only charge beneficiaries for any cost-sharing amounts allowed under the individual State program.

While Medicaid has improved access to medical care for low-income persons, critics of the program contend that there are still barriers to care and that Medicaid has failed to bring its beneficiaries into the mainstream of the health care system.

The willingness of physicians to accept Medicaid patients varies by specialty. Surgical specialists and primary care physicians are most likely to accept Medicaid, while obstetricians and psychiatrists are the least likely. Low Medicaid fee schedules, relative to physicians' usual charges to other payers, are a major deterrent to participation. Studies in the late 1970's found that Medicaid physician payment rates were equal to 70 to 75 percent of private fees for equivalent services. More recent data suggest that the gap between Medicaid and private rates may have widened somewhat. However, there is considerable variation among the States.

Virtually all hospitals participate in Medicaid. However, the extent of participation varies widely. For inpatient services, Medicaid beneficiaries are much more likely to be treated in public non-Federal hospitals than are other patients, and are less likely to be admitted to private for-profit facilities.

Physicians have reported in surveys that some facilities are actively discouraging admission of Medicaid patients, and studies of patients transferred from other hospitals to public hospital emergency rooms indicate that some hospitals may be turning away Medicaid beneficiaries in need of urgent care. Factors other than a hospital's admission policies, such as location or the nature of the hospital's services may affect a hospital's Medicaid caseload. At least in some States, however, hospitals may be reluctant to admit Medicaid patients because of Medicaid reimbursement rates or coverage policies.

Medicaid is the most important source of coverage for nursing home services. However, there are indications that some Medicaid beneficiaries face problems in obtaining access to nursing home services. Medicaid beneficiaries are potentially at a disadvantage in the competition for nursing home placement. On average, Medicaid nursing home rates nationally are lower than the rates charged to self-pay patients or to Medicare. Although national patterns are not clear, there are numerous reports of discrimination by individual facilities against Medicaid beneficiaries.

5. ALTERNATIVE DELIVERY AND PAYMENT SYSTEMS

States also vary in the extent to which they are exploring innovative methods of delivering or paying for Medicaid services. States have always been permitted to arrange for the enrollment of Medicaid beneficiaries under contracts with health maintenance organizations (HMOs) or comparable organizations. In these entities, the contractor agrees to make available a specified set of medical services in return for a fixed monthly premium payment paid by Medicaid for each enrolled beneficiary. Depending on the nature and cost of services required by enrollees, the organization may realize a profit or suffer a loss; it is "at risk" for the set of services covered by the contract. This arrangement is intended to give the organization a financial incentive not to furnish unnecessary services.

Legislation enacted in 1981, established two new options—the "2175" (freedom-of-choice) and "2176" (home and community-based services) waiver programs.[4] Under these programs, the Secretary is able to waive certain statutory requirements in order to allow a State to develop cost-effective alternative methods of service delivery or reimbursement. The purpose of these provisions is to give States greater flexibility in managing their Medicaid programs.

Under Section 2175, States may obtain waivers of "freedom-of-choice" (the requirement that beneficiaries be allowed to use any participating provider) and other requirements to develop innovative health care delivery or reimbursement systems. The State may establish a primary care case management program under which beneficiaries may obtain covered services only with the authorization of a single primary care provider, the "case manager". Like HMO contracts, these programs are intended to reduce the use of unnecessary services and provide better overall coordination of beneficiaries' care.

The Section 2176 waiver program allows States to develop a coordinated package of services for a specified group of individuals (such as the aged, disabled, persons with mental retardation, or persons with AIDS) who would otherwise be at the risk of institutionalization, or who are already receiving institutional care and need help to return to the community. States may offer additional services, often nonmedical in nature, to the participants without making them available to other Medicaid beneficiaries, and may include social services that could not ordinarily be covered under Medicaid. The State must show that the costs of its waiver program are no higher than the costs which would have been incurred if the participants had been treated in a nursing home or a hospital.

States are also periodically granted waivers of Medicaid requirements in order to conduct demonstration projects. These special projects, authorized by the Secretary under general waiver authorities or specifically mandated by Congress, allow for tests of possible program improvements.

6. DISTRIBUTION OF PAYMENTS AND BENEFICIARIES

The combination of individual State decisions with respect to eligibility, services, and payments has resulted in a situation where there are effectively 55 different Medicaid programs in the country namely, one in each State (except Arizona, which is operating an alternative demonstration program), the District of Columbia, and five territories. Some programs offer fairly generous coverage while others offer more limited coverage. The distribution of program payments across States reflects these variations as well as other factors such as total population and the percentage of that population which is low income. In 1986, two States, California and New York, accounted for over 30 percent of payments for services, while 7 States accounted for over 50 percent. Similarly, over one-quarter of beneficiaries were in New York and California and seven States accounted for over 50 percent of the beneficiaries.

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[4] The "2175" and "2176" waivers refer to the section number of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) which authorized these waivers.

C. Differences Among Populations Served

Despite these variations, some common themes emerge across the States. Medicaid has essentially evolved into three distinct programs. The first serves children and related adults, the second serves the elderly, and the third is targeted toward persons with mental retardation. The characteristics of each population group, the mix of services provided, and overall spending differ markedly among these three groups.

1. CHILDREN AND RELATED ADULTS

Children and adults in families with dependent children accounted for approximately 70 percent of beneficiaries but only 24 percent of payments in fiscal year 1986.[5] Approximately two-thirds of this population were children. Children generally have patterns of illness which are different from those of adults. Children may become ill more often, but their illnesses are generally less serious and are often "self-curing".

Most children require episodic treatment for acute illnesses. Treatment is most frequently provided in physician's offices though hospital outpatient departments may also serve as a source of care. Children not only visit physician's offices for treatment of acute illnesses but also for preventive health care.

Some children also require care for chronic conditions—conditions which last for a substantial period of time. Most children with chronic conditions have mild conditions, such as mild cases of asthma; however a small percentage have conditions that limit their daily life activities, such as a severe congenital heart defect.

The health care needs of children are reflected in their use of Medicaid services. The preponderance of services used by this population can be classified as ambulatory care services. Physician's services are the most widely used; 6.5 million children received such services in 1986. Outpatient hospital services were used by 4.5 million children, dental services by 2.7 million, laboratory and x-ray services by 2.5 million, and prescription drugs by 5.9 million. By contrast, inpatient hospital services were used by under one million children.

Children of different ages had different patterns of service use. For example, the likelihood of inpatient hospitalization is generally greater for very young children and for older teenage children. Older disabled children are higher users of long-term care services.

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[5] If beneficiaries classified as "other" (which include mostly children and related adults) are added to this total, the percentage of beneficiaries increases to 76 percent while the percentage of payments increases to 27 percent.

Despite the greater use of ambulatory care services by children, 47 percent of Medicaid spending for children in fiscal year 1986—$2.4 billion—represented payments for inpatient hospital services. By contrast, spending for physician's services totalled 13.3 percent ($684 million) and that for outpatient hospital services 12.8 percent ($656 million).

2. AGED

The patterns of service use and expenditures for the adult categories—primarily the aged—differ markedly from that recorded for children. (See figure I-4.) In fiscal year 1986 the elderly composed only 14 percent of beneficiaries but accounted for 37 percent of total Medicaid spending. The elderly covered by Medicaid can be viewed as two groups. The first group is composed of persons who qualify for coverage by virtue of their having income low enough to qualify them for cash welfare assistance. These persons represent 54 percent of elderly Medicaid beneficiaries but account for only 25 percent of total program payments for the aged. The second group is composed primarily of persons who have incomes above cash welfare assistance levels but who incur expenses for medical care that exceeds their income and assets. Both groups have very limited liquid resources.

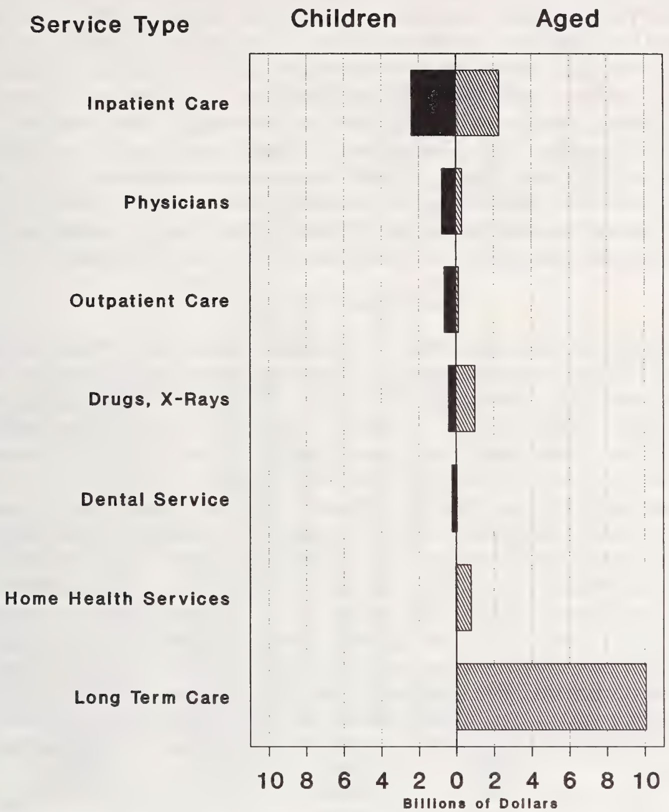
This second group includes many persons who use nursing home care. In fact, Medicaid spending for nursing home care is driven by coverage of elderly beneficiaries who do not receive cash welfare payments. These persons are not initially poor according to welfare standards. Many in fact may be middle income before their entrance into a nursing home. However, with nursing home costs in the range of $22,000 a year in 1987, many elderly persons in nursing homes can quickly meet Medicaid's eligibility requirements. These persons do so by spending their resources and incomes on the cost of care down to levels that make them eligible for Medicaid in their State.

In fiscal year 1986, 38 percent of the aged used nursing home services, accounting for two-thirds of total payments made for the elderly. Seventy percent of the elderly not receiving cash assistance payments used nursing home services; payments for these persons amounted to 58 percent of total Medicaid payments for all elderly beneficiaries.

Nursing home payments were seven times as large a share of total payments for aged beneficiaries as they were for nonaged beneficiaries. The difference in the distribution of payments for services for aged and nonaged beneficiaries is in part the result of elderly individuals needing and using nursing home care more often than younger age groups. The 1985 National Nursing Home Survey found that of the total number of persons residing in nursing homes at the time of the survey, 88 percent were 65 years of age and older. Nearly 84 percent of these elderly persons were 75 years of age and older.

The different pattern in payments for services for the elderly and nonelderly beneficiaries also reflects the fact that most elderly Medicaid beneficiaries are covered under the Medicare program as

Figure I-4
Payments for Selected Medicaid Services for Children and the Aged, FY 1986



Spending on Children's Home Health Services, & Long Term Care, as well as Aged Dental Care equalled less than $100 million.

Source: HCFA form 2082.

well. For these dually eligible individuals, Medicare is the primary payer for the services it covers in common with Medicaid, such as hospital services and physicians services. Medicare has only very limited coverage for nursing home care, both in terms of the days of care that are covered and the conditions under which a person may qualify for the benefit. Private insurance coverage of nursing home services is also limited at this time. As a result, Medicaid has become the Nation's major source of financial support for persons needing nursing home care accounting for 41 percent of the total.[6] The only other major source of funding for nursing home care is not a formal program of support or coverage, but rather the private out-of-pocket payments individuals and their families make for the cost of care. Such private payments amounted to 51 percent of total national spending for nursing home care in 1986. A portion of this out-of-pocket spending includes payments made by institutionalized persons prior to their qualifying for Medicaid.

3. MENTALLY RETARDED

An important component of Medicaid spending for nursing home services is the portion spent on intermediate care facility services for the mentally retarded (ICF/MR). The ICF/MR population represents the third major coverage category under Medicaid. Most Medicaid services designed specifically for persons with mental retardation are delivered in ICFs/MR, though the program does provide coverage for all health related services delivered to such persons provided they meet the program's eligibility requirements. In 1986, 145,000 beneficiaries (0.6 percent of total beneficiaries) used ICF/MR services at a total cost of $5.2 billion or 12 percent of total benefit payments. ICFs/MR range in size from State or private facilities of 15 beds or fewer to very large State-operated institutions over 1,000 beds. An estimated $450 million in Medicaid funds was spent on community-based services for this population group. However, most community-based services for persons with mental retardation or related conditions are supported under separate State programs.

4. PER CAPITA SPENDING PATTERNS

The variation in service use across the three major coverage categories—children and related adults, the aged, and the ICF/MR population—is reflected in per capita spending data. Nationwide per capita spending in fiscal year 1986 was $1,970.[7] Per capita spending ranged from $521 for dependent children receiving cash assistance, $952 for adults in families with such dependent children, and $8,646 for the aged population not receiving cash assistance. (See figure I–5). Per capita spending for persons using ICF/MR services totalled $35,139;[8] however, this figure does not include the cost of other services provided to persons with mental retardation.

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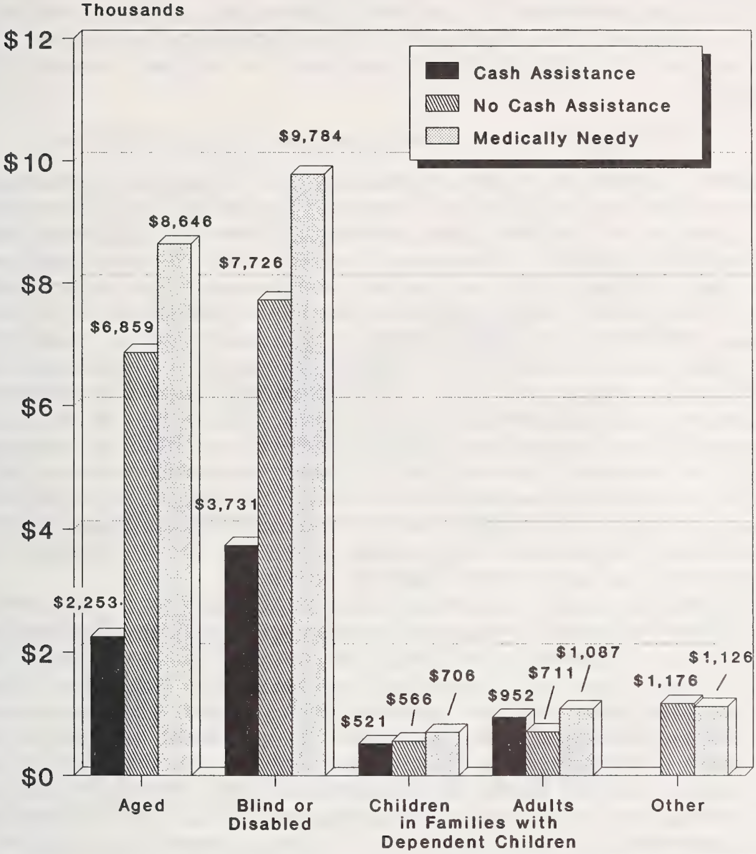
[6] This represents a percentage of spending for all long-term care services including those provided in an intermediate care facility for the mentally retarded.

[7] This figure excludes the territories.

[8] This figure is different from the per capita data reflected in figure I–4. That figure includes Medicaid expenditures for all of the disabled, not just the ICF/MR population.

Figure I-5
Medicaid Payments Per Beneficiary
FY 1986



Source: HCFA form 2082.

5. DISTRIBUTION BY RACE/ETHNIC GROUP

In 1986, 53 percent of the beneficiaries were white, 27 percent were black, 8 percent were Hispanic, and 3 percent were of other races or ethnicity or their racial characteristics were unknown. (See figure I–6.) The distribution of payments for these population groups was considerably different; whites accounted for 73 percent while blacks accounted 21 percent, Hispanics 4 percent and other groups 3 percent. (See Figure I–7.) These figures reflect, in part, the greater use of long-term care services by whites versus other groups.

D. Recent Changes/Implications for the Future

Several recent changes enacted by the Congress, particularly those related to eligibility, will have an impact on the future shape and direction of the Medicaid program. These changes were made in response to several concerns. One was that the program's welfare link, coupled with low income and resource levels, prevented many poor persons from obtaining Medicaid protection. In order to expand Medicaid coverage, States would have had to raise their cash assistance levels which many of them were unwilling to do.

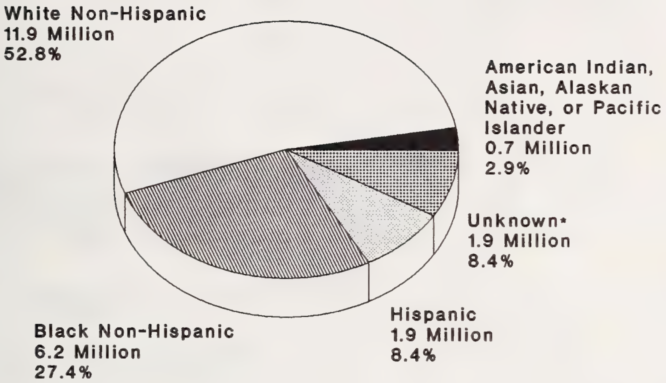
While this was an issue for all population groups, the absence of protection for some pregnant women and infants was of particular concern. A low income pregnant woman without Medicaid coverage might be deterred from seeking necessary prenatal care—an effective way to reduce the incidence of low birthweight, a major determinant of infant mortality. Low income children are more likely to go without a physician visit during a year or see a physician less frequently than those with Medicaid coverage.

Concerns about the uncovered poor population were not restricted to those relating to pregnant women and children. The vast majority of aged persons have Medicare coverage; however many low-income aged have no supplementary insurance protection. Medicare's cost-sharing charges, together with payments for services not covered by Medicare, could represent a significant burden for persons with limited incomes. There was also the concern that spouses of institutionalized Medicaid beneficiaries were forced to impoverish themselves before the institutionalized spouse could have Medicaid payments made in their behalf. (This is sometimes referred to as spousal impoverishment.)

A connection to cash assistance is still the primary but no longer the only way to establish Medicaid eligibility. States are now required to cover all pregnant women meeting their State's income and resources requirements, whether or not they are receiving cash assistance. They are also required to phase-in coverage of all children under age 7 who meet such income and resource requirements.

Beginning in 1987, States were given the option of extending their programs to cover certain low-income groups with incomes between the existing State eligibility standards and a State-defined level below the poverty line. The first group is pregnant women, infants, and children under age 8 born after September 30, 1983. Beginning July 1, 1988, this group may be expanded by each State to include pregnant women and infants up to age 1 with incomes

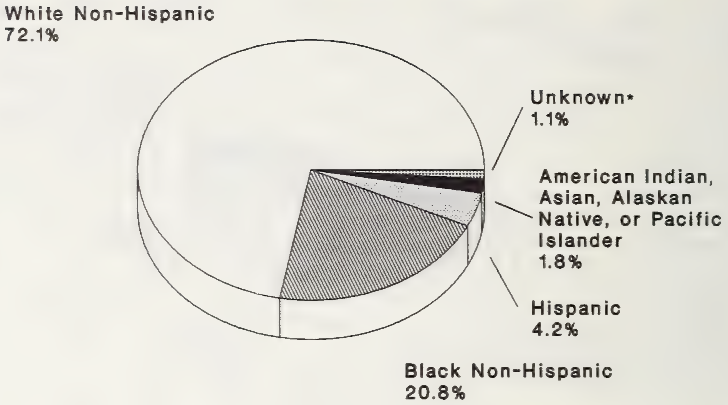
Figure I-6
Race / Ethnicity of Medicaid
Beneficiaries, FY 1986



* Racial Characteristics not reported in Maine, Puerto Rico and the Virgin Islands.

Source: HCFA form 2082.

Figure I-7
Medicaid Payments by Race / Ethnicity
FY 1986



* Racial characteristics not reported in Maine, Puerto Rico, and the Virgin Islands.

Source: HCFA form 2082.

below 185 percent of poverty. The second group is elderly and disabled persons. For this second group, States may either provide full Medicaid coverage or, alternatively, cover just Medicare cost-sharing expenses.

Beginning in 1989, States will be required to phase-in protection for some members of these groups whose coverage was previously optional. The Medicare Catastrophic Coverage Act of 1988 (Public Law 100–360) mandates States to phase-in over a 2-year period, beginning July 1989, Medicaid coverage for pregnant women and infants below the poverty line. It also mandates States to phase-in over 4 years, beginning January 1, 1989, payment of Medicare premiums and cost-sharing charges in behalf of the elderly and disabled below the poverty line. Further, the legislation incorporates major changes in Medicaid's treatment of income and resources of a couple when one member of the couple is institutionalized; these changes which are effective September 30, 1989, are intended to protect against so-called spousal impoverishment.

These changes in Medicaid eligibility rules will have the effect of increasing the percentage of the poverty population covered by Medicaid and can be expected to result in a slight overall increase in the total Medicaid population. The modifications in the spousal impoverishment provisions will result in an increase in Medicaid spending for institutionalized persons who have a spouse in the community.

Changes in eligibility policy are not the only factors which will shape the Medicaid program in the future. A number of studies have projected major increases in both the nursing home population and the disabled elderly population living in the community. These trends will have important implications for Medicaid spending. The Health Care Financing Administration has projected that Medicaid spending for nursing home care will triple by the year 2,000 under current policies. However, any changes in either public and private approaches to financing both nursing home and alternative community-based care could alter future Medicaid spending patterns.

Another population group which may have major implications for Medicaid spending is persons with acquired immunodeficiency syndrome (AIDS). Current estimates suggest that as many as 40 percent of all AIDS patients become eligible for Medicaid benefits at some point in the course of their illness. Medicaid's share of total costs for these patients is somewhat lower, perhaps in the range of 20 to 30 percent, because some persons with AIDS qualify for Medicaid only after having been ill for some time. Medicaid's role in financing health services for persons with AIDS may expand in the future, both because of changes in the nature of the population developing AIDS and because other forms of insurance coverage may become less available to persons with AIDS.

II. TRENDS IN THE MEDICAID PROGRAM

In 1966, Medicaid and Kerr-Mills spending represented 3.3 percent of all U.S. health expenditures. By 1986, Medicaid's contribution of $45.8 billion to the Gross National Product represented 10 percent of all health expenditures; almost one out of every five

Federal health dollars and 36 percent of all State and local health expenditures. Over this same 20 year period the number of Medicaid beneficiaries almost doubled from 11.5 to 22.5 million people.

This long term trend reflects a number of different changes in the program. In its early years, program start up and increases in the number of eligible beneficiaries resulted in rapid increases in spending. During the seventies a number of additional services like intermediate care for the mentally retarded became part of many State programs; these additional services contributed to additional but somewhat more moderate program growth. More recently, States have attempted to constrain program spending, but still provide adequate access to medical care for program beneficiaries.

The purpose of this section of the overview is to provide information on general trends in Medicaid payments and beneficiaries. Payment trends will be adjusted for inflation and beneficiary levels, and trends in selected services and eligibility categories will be described.

A. SUMMARY

The Medicaid program provides payments to providers of health services. The overall payments associated with these services are influenced by the number of beneficiaries of these services, the types of services these beneficiaries use, the degree of use of these services, and the method of reimbursement for these services. In addition, program spending is influenced by factors that are not a part of the program, for example, the inflation rate in the health sector of the economy. These factors have contributed to the following program trends:

(a) Overall Program Spending Trends:

—Medicaid spending increased at an annual average rate of 14.7 percent between 1968 and 1986 [9];

—But the rate of spending growth has slowed. Between 1968 and 1974, Medicaid spending increased at an average annual rate of 18.9 percent; between 1980 and 1986, Medicaid's spending grew at an average annual rate of 9.9 percent;

—Taking inflation into account, between 1968 and 1986, adjusted Medicaid spending grew at an average annual rate of 6.2 percent. Inflation adjusted spending declined in fiscal years 1982 and 1984;

(b) Overall Program Beneficiary Trends:

—After substantial increases in their number between 1968 and 1974, the number of Medicaid beneficiaries has oscillated between 21.5 and 22.8 million. The number of beneficiaries peaked in 1977 at 22.8 million, but during the late seventies the number declined; by 1983 there were 21.6 million Medicaid beneficiaries;

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[9] This chapter will provide information on overall Medicaid payments and beneficiaries from 1968 through 1986. It was not until 1973 that States began using HCFA form 2082. Data from this form provides detailed annual State level payment and beneficiary information. HCFA form 2082 data is the primary data source for this chapter. The sections describing trends in overall payments and beneficiaries will use the earlier year's data since it describes the Medicaid program's starting years. Data prior to 1973 is less reliable and should be viewed with some caution. Detailed analyses of the payments and beneficiaries in later sections of this chapter will rely only on information from the HCFA 2082 forms, these analyses will begin with fiscal year 1975.

—Since 1983 the number of Medicaid beneficiaries has increased by 4 percent. The 3.2 percent increase in beneficiaries between 1985 and 1986 is the largest single year increase in the program since 1976.

(c) Service Trends:

—Payments for inpatient hospital care and long term institutional care (skilled nursing facilities and intermediate care facilities) always have represented the largest share of Medicaid spending. But the share spent on these services has declined since 1975;

—Those service categories that represent the largest share of Medicaid spending (inpatient hospital care and long term institutional care) do not represent the largest number of beneficiaries (services categories with the most beneficiaries include: physician services, prescribed drugs, and outpatient services);

—Payments for intermediate care facilities for the mentally retarded, outpatient services, and home health services represent a larger component of Medicaid spending in 1986 than in 1975;

—Individual service category trends suggest that Medicaid beneficiaries are using more major services. While there have been modest changes in the overall number of Medicaid beneficiaries, most individual service categories experienced substantial increases in the number of beneficiaries between 1975 and 1986;

(d) Eligibility Trends:

—A larger share of Medicaid payments are being used for services for the aged, disabled and blind. In 1975, 61 percent of all Medicaid payments were paid for services to this group; in 1986, 73 percent;

—Since 1980, the number of children in dependent families covered by Medicaid increased, while the number of aged beneficiaries has declined. The decline in aged beneficiaries is associated with the decline in the number of aged SSI recipients.

—Between 1975 and 1986, the number of Medicaid beneficiaries receiving cash assistance payments (AFDC or SSI) declined by less than a half of a percent; the number of beneficiaries eligible for Medicaid as a result of high medical expenses declined by over 7 percent; and the number of beneficiaries who have low incomes but do not receive cash assistance payments increased by 115 percent.

—In 1986, beneficiaries eligible for Medicaid as a result of cash assistance payments made up 51 percent of the beneficiaries, those in Medical need made up 27 percent, and those with low-incomes not receiving cash assistance, 21.3 percent.

B. Overall Trend in Medicaid Payments and Beneficiaries

1. TRENDS IN OVERALL VENDOR PAYMENTS AND BENEFICIARIES

Table I–1 portrays the trend in Medicaid vendor payments and beneficiaries from 1968 to 1986. Vendor payments represent all payments to physicians, hospitals, long term care facilities and other health providers. These payments represent funds from Federal, State and local sources. Administrative spending, and premiums to Medicare Part B or Health Maintenance Organizations are excluded (see Chapter V and Appendix C).

Table I–1.—MEDICAID PAYMENTS AND BENEFICIARIES, FISCAL YEARS 1968–86

Fiscal Year [1]	Medicaid Payments (in Millions)	Annual Percentage Change	Medicaid Beneficiaries (in Thousands)	Annual Percentage Change
1968	$3,451		11,500	
1969	4,351	26.1	12,060	4.9
1970	5,094	17.1	14,507	20.3
1971	6,345	24.6	17,965	23.8
1972	7,346	15.8	17,741	−1.2
1973	8,713	18.6	18,466	4.1
1974	9,738	11.8	21,114	14.3
1975	12,242	22.6	22,007	2.5
1976	14,091	15.1	22,815	3.7
1977	16,239	15.2	22,831	0.1
1978	17,992	10.8	21,965	3.8
1979	20,472	13.8	21,520	2.0
1980	23,311	13.9	21,605	0.4
1981	27,204	16.7	21,980	1.7
1982	29,399	8.1	21,603	1.7
1983	32,391	10.2	21,554	0.2
1984	33,891	4.6	21,607	0.2
1985	37,508	10.7	21,814	1.0
1986	41,027	9.4	22,518	3.2
Percentage Increase 1968–86		1,089		95.8
Average Annual Rate of Growth 1968–86 (percent)		14.7		3.8

[1] Federal fiscal years ended in June through 1976, all subsequent fiscal years end in September.

Note: All estimates include spending for the States, the District of Columbia, the Virgin Islands and Puerto Rico.

Source: All figures are estimates. Estimates from 1968 through 1974 are obtained from U.S. House of Representatives, Subcommittee on Health and the Environment. "Data on the Medicaid Program: Eligibility, Services, Expenditures Fiscal Year 1966–76." Committee Print No. 18, 94th Congress. Data for 1975 through 1986 are based on information contained on HCFA form 2082. All estimates are subject to data limitations and methods employed in their calculation.

During the seventies, as almost all the States began to participate in the program, Medicaid's growth was rapid. This rapid growth contributed to a 1,089 percent increase in spending between 1968 and 1986. But, this long term comparison hides a number of important aspects of change in the program. For example, while Medicaid spending has increased rapidly, the rate of this increase has slowed.

In 1968, Medicaid payments equalled $3.5 billion.[10] As additional States became involved in the program these payments grew; by 1974, Medicaid spending equalled $10 billion. Throughout the seventies, there was continued growth; by 1980, the total payments equalled $23 billion. In the last 6 years, the program's cost containment efforts helped slow the rate of growth; but 1986 Medicaid payments were close to $41 billion. Figure I–8 depicts this trend in Medicaid payments. The line in the chart depicts the overall growth in the program's payments; the bars represent the annual percentage change. Comparing the height of the bars over time provides an indication of how rapidly Medicaid payments are rising from year to year.

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[10] This amount includes spending for the Kerr-Mills and related programs that made medical vendor payments for the aged receiving cash assistance or the aged in medical need.

As depicted in figure I–8, the 1968 to 1976 period was one of relatively high increases in payments, between 1977 and 1981 the rate of increase in program spending was more modest—but was increasing from year to year, in the more recent 1981 to 1986 period, the rate of payment increases has been relatively slow when compared to earlier years.

Another important aspect of Medicaid's overall payment growth can be seen in Table I–1. After the early years of the program, increases in overall Medicaid payments do not appear to be the result of large increases in the overall number of beneficiaries.

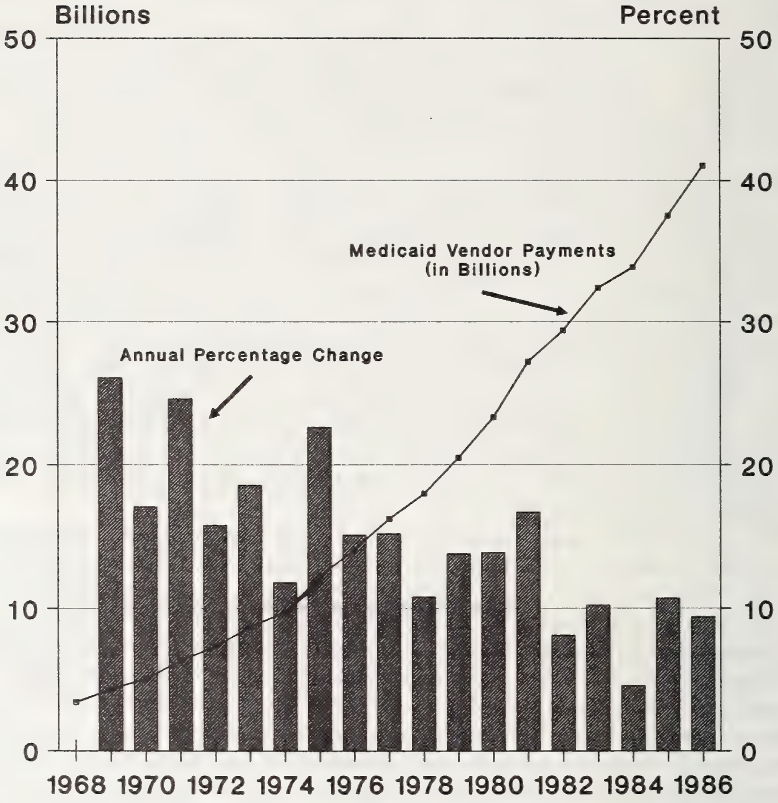
The 1968 through 1974 time period saw a rapid growth in the number of beneficiaries. Most of this early growth can be attributed to individual States starting Medicaid programs, as well as increases in the number of individuals who became eligible for the program through the Aid to Families with Dependent Children (AFDC) program. After 1974, the rate of growth in the number of beneficiaries was more gradual. The total number of Medicaid beneficiaries peaked in 1977 at 22.8 million. Between 1977 and 1983 the number of beneficiaries declined to 21.6 million. But over the last three fiscal years, legislative changes expanding eligibility have resulted in continuous increases in the number of beneficiaries (see chapter II and chapter VIII). The 3.2 percent increase in beneficiaries in 1986 represents the largest single year increase in the program since 1976.

The program's beneficiary trends do not coincide with changes in the size of the poverty population (see figure I–9). For example, between 1968 and 1975 with States entering the program, the number of Medicaid beneficiaries increased by 98 percent. In contrast, the number of poor declined and then as a result of the mid seventies recession, returned to earlier levels. Between 1977 and 1983 the number of the poor increased by 42.8 percent, much of this increase was a result of increases in the number of poor people in two-parent families. These are families that often were excluded from Medicaid eligibility (see Chapter II and Appendix A). From 1977 to 1983, the number of Medicaid beneficiaries declined by 5.5 percent. Most recently, the number of Medicaid beneficiaries has increased slightly while the number of the poor has declined slightly.

As will be discussed more thoroughly in Chapters II and Appendix A, this finding is not all that surprising. While Medicaid is a means-test entitlement program, this does not imply that every poor persons is eligible for coverage. For example, nonaged nondisabled childless couples, and single individuals are generally not eligible. In addition to limited groups of the poor being eligible, over the past few years, Aid to Families with Dependent Children (AFDC) benefit levels have not kept pace with inflation, this has the effect of making AFDC more restrictive, further limiting the

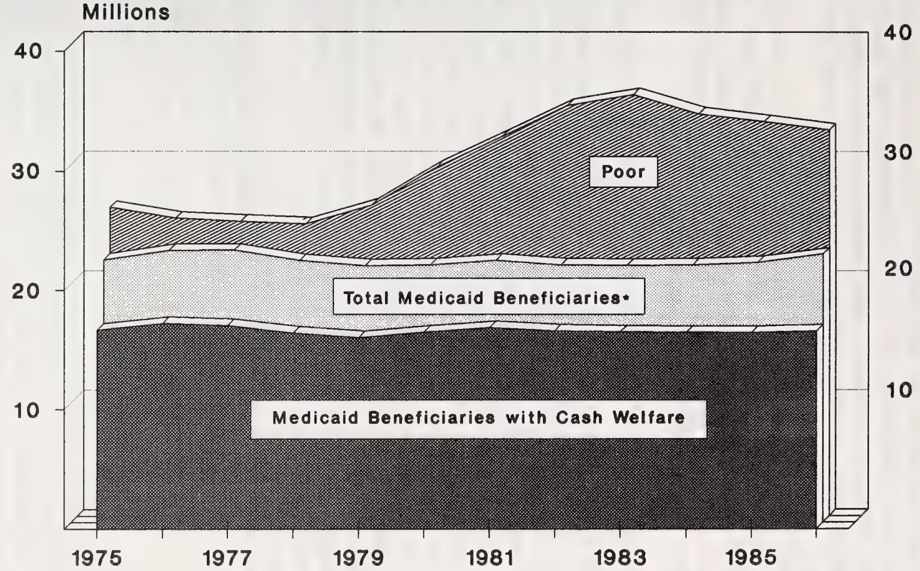
Figure I - 8

Medicaid Vendor Payments, Fiscal Year 1968 - 1986



Source: See Table I-1.

Figure I-9
Trends in the Poverty Population and Medicaid Population, 1975-1986



* Total Medicaid beneficiary counts include some individuals with total cash income above the poverty line.

Source: Census Bureau and HCFA

number of poor covered by Medicaid.[11] Recent legislative changes breaking this link between the AFDC program and Medicaid coverage for poor pregnant women and young children should result in moderate increases in the number of poor covered by the health program.

Since many States provide Medicaid services to individuals who have large medical expenses, a share of the Medicaid population consists of the nonpoor (see Appendix A). This also contributes to the lack of an obvious association between the trends in the poverty population and the Medicaid population.

2. OVERALL MEDICAID PAYMENTS ADJUSTED FOR INFLATION

During the last 20 years, the inflation rate in the health sector of the economy, as measured by the Consumer Price Index for medical care (CPI-MC), generally has been higher than the overall inflation rate.[12] Despite this relatively high inflation rate, during the sixties and seventies overall Medicaid payments outpaced health sector price increases. However, in the eighties, overall payments have not kept pace with health sector prices. Table I-2 and figure I-10 depicts the trend in total Medicaid payments after adjustment for inflation using the Consumer Price Index—medical care component (CPI-MC).[13] After adjustment for trends in medical care price levels, Medicaid overall payments increased at a 6.2 percent average annual rate between 1968 and 1986.

Table I-2.—MEDICAID PAYMENTS IN CONSTANT 1986 DOLLARS, FISCAL YEARS 1968-86

Fiscal Year [1]	Constant Dollar Payments (in Millions of 1986 Dollars)	Annual Percentage Change
1968	$14,250	
1969	16,989	19.2
1970	18,570	9.3
1971	21,625	16.5
1972	23,921	10.6
1973	27,519	15.0
1974	29,099	5.7
1975	32,517	11.7
1976	33,967	4.5
1977	34,899	2.7
1978	35,855	2.7
1979	37,184	3.7
1980	38,246	2.9
1981	40,446	5.8

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[11] See Brian O. Burwell and Marilyn P. Rymer, "Trends in Medicaid Eligibility: 1975 to 1985." Health Affairs, Winter 1987. pp. 30-45. Also see U.S. House of Representatives. Committee on Ways and Means. Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means. 1988 Edition. Committee Print. WMCP 100-29. March 24, 1988. p. 663.

[12] See James Reuter, "Health Care Expenditures and Prices", Congressional Research Service, Issue Brief IB77066.

[13] This adjustment of Medicaid payment levels with the CPI measure of inflation must be viewed with some caution. This is the case because the CPI series measures the inflation rate in out of pocket medical expenses. Since Medicaid's reimbursement policies may not reflect the year to year changes in these out of pocket expenses, the CPI inflation adjustment may overstate the impact of inflation on Medicaid payments. In addition, medical services paid for out of pocket may not correspond to the same mix of services provided by Medicaid.

Table I–2.—MEDICAID PAYMENTS IN CONSTANT 1986 DOLLARS, FISCAL YEARS 1968–86—Continued

Fiscal Year [1]	Constant Dollar Payments (in Millions of 1986 Dollars)	Annual Percentage Change
1982	39,066	−3.4
1983	39,249	0.5
1984	38,568	−1.7
1985	40,228	4.3
1986	41,027	2.0
Percentage Increase 1968–86		188
Average Annual Rate of Growth 1968–86 (percent)		6.2

[1] Federal fiscal years ended in June through 1976, all subsequent fiscal years ended in September.

Note: All dollar amounts are in millions. Medicaid payment amounts adjusted using the Consumer Price Index for Medical Care (CPI–MC). All estimates include spending for the fifty States, the District of Columbia, the Virgin Islands and Puerto Rico.

Source: All figures are estimates based on information contained in the following two data sources. 1968–74 estimates are based on data contained in U.S. House of Representatives, Subcommittee on Health and the Environment. "Data on the Medicaid Program: Eligibility, Services, Expenditures, Fiscal Years 1966–76." Committee Print No. 18, 94th Congress. 1975–86 estimates are based on data contained on HCFA forms 2082.

There appear to be three periods of change in overall Medicaid spending. Between 1968 and 1974, after adjustment for inflation, payments grew at a 12.6 percent average annual rate. During the 1974–80 period, when inflation in the health sector ranged between 9 and 12 percent annually (inflation rates much larger than the rates in the earlier period), adjusted Medicaid payments increased by 4.7 percent on an average annual basis. More recently, between 1980 and 1986, inflation adjusted Medicaid payments increased by 1.2 percent. Adjusted program payments actually declined between 1981 and 1982, and between 1983 and 1984.

3. PAYMENT PER BENEFICIARY

Table I–3, portraying payments per beneficiary, combines the trends in beneficiaries with the previously discussed payment information. The overall increase in program spending and the relatively flat trend in the number of beneficiaries results in an almost continuous increase in Medicaid payments per beneficiary over the 18 years of data. Between 1968 and 1986, Medicaid payments per beneficiary increased at an average annual rate of 10.5 percent.

Table I–3.—MEDICAID PAYMENTS PER BENEFICIARY, IN NOMINAL AND CONSTANT 1986 DOLLARS, FISCAL YEARS 1968–86

Fiscal Year [1]	Payments per Beneficiary	Annual Percentage Change	Constant 1986 Dollar Payment per Beneficiary	Annual Percentage Change
1968	$300		$1,239	
1969	361	20.2	1,409	13.7
1970	351	−2.7	1,292	−9.1
1971	353	0.6	1,204	−6.0
1972	414	17.2	1,348	12.0
1973	472	14.0	$1,490	10.5
1974	461	−2.3	1,378	−7.5
1975	556	20.6	1,478	7.2

Table I-3.—MEDICAID PAYMENTS PER BENEFICIARY, IN NOMINAL AND CONSTANT 1986 DOLLARS, FISCAL YEARS 1968–86—Continued

Fiscal Year [1]	Payments per Beneficiary	Annual Percentage Change	Constant 1986 Dollar Payment per Beneficiary	Annual Percentage Change
1976	618	11.0	1,489	0.8
1977	711	15.2	1,529	2.7
1978	819	15.2	1,632	6.8
1979	951	16.1	1,728	5.9
1980	1,079	13.4	1,770	2.5
1981	1,238	14.7	1,840	3.9
1982	1,361	10.0	1,808	−1.7
1983	1,503	10.4	1,821	0.7
1984	1,569	4.4	1,785	−2.0
1985	1,719	9.6	1,844	3.3
1986	1,822	6.0	1,822	−1.2
Percentage Change 1968–86		507.3		47.1
Average Annual Rate of Growth 1968–86 (percent)		10.5		2.2

[1] Federal fiscal years ended in June through 1976, all subsequent fiscal years ended in September.

Note: Constant dollar payment data adjusted using the Consumer Price Index for Medical Care (CPI–MC). All estimates include spending for the States, the District of Columbia, the Virgin Islands and Puerto Rico.

Source: All figures are estimates based on information contained in the following two data sources: 1968–74 estimates are based on data contained in the U.S. House of Representatives, Subcommittee on Health and the Environment. "Data on the Medicaid Program: Eligibility, Services, Expenditures Fiscal Years 1966–76." Committee Print No. 18 94th Congress; 1975–86 estimates are based in data contained on HCFA forms 2082.

Adjusting the payment per beneficiary data for changes in price levels results in a strikingly different trend (see table I–3). Rather than a period of rapid increases followed by more modest increases or declines, the adjusted payment per beneficiary trend shows an initial period (1968–74) of fluctuating spending—during this period the program experienced some of its largest payment per beneficiary increases and declines. During the next period (1974–80), the payments per beneficiary experienced continuous moderate growth. Finally, the 1980 through 1986 period experienced the smallest average annual rate of increase—0.5 percent. This 6 year segment shows modest fluctuations in the adjusted payment per beneficiary amounts—with declines from the previous year's constant dollar payment per beneficiary occurring in 1982, 1984 and 1986.

4. MEDICAID SPENDING COMPARED TO OVERALL HEALTH SPENDING [14]

Since 1966, Medicaid spending has grown roughly three times faster than total U.S. health expenditures. But, almost all of this growth occurred between 1966 and 1975. Over its first 10 years, Medicaid's contribution to U.S. health expenditures grew from 3.3 to 10.7 percent (see table I–4). From 1975 to 1981, Medicaid spending hovered around 11 percent of total health spending. After 1981, program spending has not kept pace with other health expendi-

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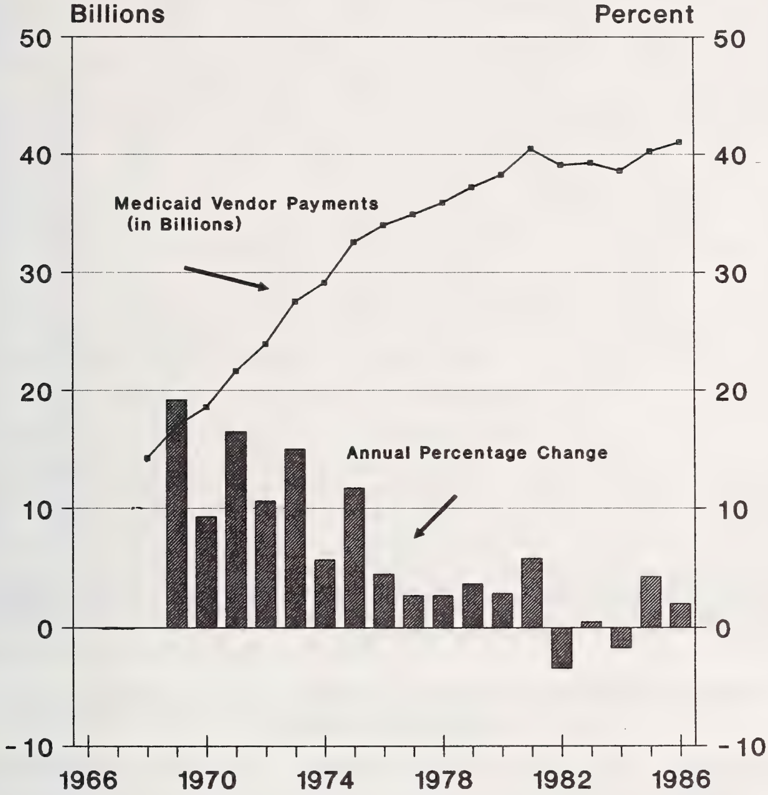
[14] The analysis in this section is based on total Medicaid and health service expenditures. These total expenditures include vendor payments as well as administrative costs and premium payments. It should also be noted that the accounting period used for this expenditure data is the calendar year.

Figure I - 10
Constant Dollar Medicaid Vendor Payments, 1968-1986



Note: All dollar amounts are in 1986 constant dollars.
Source: See table I-3.

tures, in 1982 it dropped to 10.2 percent of total spending and since has dropped to 10 percent.

Table I–4.—A COMPARISON OF THE TREND IN NATIONAL HEALTH EXPENDITURES AND MEDICAID EXPENDITURES, CALENDAR YEARS 1966–86

[All Dollar Amounts are in Millions]

Calendar Year	Total National Health Expenditures	Medicaid	Medicaid as a Percent of Total
1966	$46,267	$1,512	3.3
1967	51,456	2,982	5.8
1968	58,219	3,950	6.8
1969	65,633	4,557	6.9
1970	74,995	5,471	7.3
1971	83,484	7,076	8.5
1972	93,968	8,541	9.1
1973	103,382	9,676	9.4
1974	116,113	11,287	9.7
1975	132,680	14,153	10.7
1976	150,760	15,836	10.5
1977	169,855	17,721	10.4
1978	189,657	19,812	10.4
1979	214,659	22,867	10.7
1980	248,110	26,482	10.7
1981	286,975	30,449	10.6
1982	323,635	32,885	10.2
1983	357,184	35,670	10.0
1984	391,070	38,286	9.8
1985	422,593	42,191	10.0
1986	458,214	45,782	10.0

Note: All dollar figures are in millions. Expenditure information includes administrative costs as well as vendor payments for medical services. These Medicaid figures differ from other amounts in this chapter not only because they include administrative costs, but also because they are for calendar years rather than fiscal year.

Source: Office of the Actuary, Office of National Health Cost Estimates. HCFA.

5. TRENDS IN FEDERAL MEDICAID SPENDING AND STATE AND LOCAL MEDICAID SPENDING

Medicaid's costs are shared by Federal and State governments. The Federal Government matches State funding using a formula based upon a State's per capita income (see Chapter VII). Table I–5 provides details on Federal and State shares of total spending.

a. State and Local Medicaid Spending

State Medicaid spending represents a major State level expenditure. Since 1975, State Medicaid spending has represented at least 32 percent of total State and local spending on health services. Since 1983, Medicaid's share of State and local health spending has increased to about 36 or 37 percent of State health spending.

Besides Medicaid, State and local health spending includes expenditures on items like: public health activities, workers compensation, State and local hospitals, vocational rehabilitation, maternal and child health programs, temporary disability medical insurance payments, and other items. Medicaid represents the single largest category of State and local health spending. Medicaid's significant role in State and local spending was probably one of the factors for some of the programs recent changes (see Chapter VIII). Increased flexibility in the way services are provided (Chapter V), innovations in the methods of reimbursement (Chapter IV) and the use of managed care delivery services (Appendix F) gained some impetus from the importance of Medicaid in State expenditures.

A recent study noted that a number of factors affect State spending on Medicaid.[15] First, the open-ended nature of Federal matching funds allows States to purchase more health care per State dollar in the Medicaid program than when the State purchases health care services without the Federal matching amount. This may act to stimulate State Medicaid spending, and likely contributes to Medicaid's relative growth in the share of State health spending. At the same time, the entitlement nature of Medicaid makes it relatively more difficult for States to control expenditures than in programs where their spending is strictly set by an appropriation amount. The entitlement nature of the program means that State (and Federal matching amounts) are largely determined by the behavior of providers and beneficiaries. States are forced to control program spending through changes in who is eligible, changes in how their medical services are provided, changes in the types of services provided, or limitations in these services.

b. Federal Medicaid and Medicare Spending

Since 1979, the growth in Federal Medicaid spending has not kept pace with other Federal health care expenditures. As a result, the trend in Medicaid's share of Federal health spending is different from that found at the State and local level. In 1979, Medicaid represented 21.4 percent of Federal spending, since then, the program's share has declined to about 19 percent. This has occurred because of the much more rapid growth rate in Medicare spending (a program that represents a significant share of Federal health spending) over this time period.

Table I–5.—STATE AND FEDERAL MEDICAID SPENDING AS A SHARE OF TOTAL STATE AND FEDERAL HEALTH SPENDING, CALENDAR YEARS 1968–86

[All Dollar Amounts are in Millions]

	State Spending			Federal Spending			
Calendar Year	Medicaid	Total Health	Share of State Health Spending	Medicaid	Total Health	Share of Federal Health Spending	Total Medicaid
1968	$1,971	$7,994	24.7	$1,979	$14,114	14.0	$3,950
1969	2,148	8,855	24.3	2,409	16,087	15.0	4,557
1970	2,470	10,098	24.5	3,001	17,675	17.0	5,471
1971	3,235	11,358	28.5	3,841	20,291	18.9	7,076
1972	3,904	12,528	31.2	4,637	22,902	20.2	8,541
1973	4,214	14,200	29.7	5,462	25,174	21.7	9,676
1974	4,889	16,613	29.4	6,398	30,417	21.0	11,287
1975	6,216	19,278	32.2	7,937	37,046	21.4	14,153
1976	6,826	20,282	33.7	9,010	42,509	21.2	15,836

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[15] Medicaid Program Evaluation: State Budget Priorities and Medicaid. Working Paper 7.2. by Davis and Gullo. Department of Health and Human Services, Health Care Financing Administration, Office of Research and Demonstration.

Table I–5.—STATE AND FEDERAL MEDICAID SPENDING AS A SHARE OF TOTAL STATE AND FEDERAL HEALTH SPENDING, CALENDAR YEARS 1968–86—Continued

[All Dollar Amounts are in Millions]

	State Spending			Federal Spending			
Calendar Year	Medicaid	Total Health	Share of State Health Spending	Medicaid	Total Health	Share of Federal Health Spending	Total Medicaid
1977	7,677	22,351	34.3	10,044	47,388	21.2	17,721
1978	8,651	25,781	33.6	11,161	53,785	20.8	19,812
1979	9,839	29,500	33.4	13,028	60,977	21.4	22,867
1980	12,031	34,167	35.2	14,451	71,004	20.4	26,482
1981	13,194	37,875	34.8	17,255	83,319	20.7	30,449
1982	14,914	42,077	35.4	17,971	93,201	19.3	32,885
1983	16,310	44,697	36.5	19,361	102,727	18.8	35,670
1984	17,648	48,088	36.7	20,638	111,635	18.5	38,286
1985	18,886	51,523	36.7	23,305	124,458	18.7	42,191
1986	20,056	55,038	36.4	25,727	134,659	19.1	45,782
Percent Change 1968–86	917.6	588.5		1,200.0	854.1		1,059
Average Annual Rate of Change 1968–86 (percent)	13.8	11.3		15.3	13.3		14.6

Note: All figures are for calendar years. Spending amounts include administrative costs as well as vendor payments for medical services. All dollar figures are in millions. These Medicaid figures differ from other amounts in this chapter not only because they include administrative costs, but also because they are for calendar years rather than for fiscal years.

Source: CRS analysis of data provided by Office of the Actuary, Office of National Health Cost Estimate. HCFA.

Figure I–11 portrays the growth in Medicaid and Medicare spending. Table I–6 provides additional information by providing Federal as well as total Medicaid expenditures. By 1967, Medicare spending was larger than Medicaid, and over the last 22 years has grown at a faster pace. Except for 1986, over the last 11 years the annual increases in total Medicare spending have been greater than those in total Medicaid spending.

Table I–6.—A COMPARISON OF FEDERAL AND TOTAL MEDICAID EXPENDITURES WITH MEDICARE EXPENDITURES, 1966–86

	Medicaid				Medicare	
	Federal		Total			
	Expenditures (in Millions)	Annual Percentage Change	Expenditures (in Millions)	Annual Percentage Change	Expenditures (in Millions)	Annual Percentage Change
1966	$734		$1,512		$1,136	
1967	1,469	100.1	2,982	97.2	4,728	316.2
1968	1,979	34.7	3,950	32.5	5,976	26.4
1969	2,409	21.7	4,556	15.3	6,916	15.7
1970	3,001	24.6	5,471	20.1	7,496	8.4
1971	3,841	28.0	7,076	29.3	8,277	10.4
1972	4,637	20.7	8,541	20.7	9,117	10.1
1973	5,462	17.8	9,676	13.3	10,134	11.2
1974	6,398	17.1	11,287	16.6	13,100	29.3
1975	7,937	24.1	14,153	25.4	16,317	24.6
1976	9,010	13.5	15,836	11.9	19,300	18.3
1977	10,044	11.5	17,721	11.9	22,525	16.7
1978	11,161	11.1	19,812	11.8	25,932	15.1
1979	13,028	16.7	22,867	15.4	30,337	17.0

Table I-6.—A COMPARISON OF FEDERAL AND TOTAL MEDICAID EXPENDITURES WITH MEDICARE EXPENDITURES, 1966-86—Continued

	Medicaid				Medicare	
	Federal		Total			
	Expenditures (in Millions)	Annual Percentage Change	Expenditures (in Millions)	Annual Percentage Change	Expenditures (in Millions)	Annual Percentage Change
1980	14,451	10.9	26,482	15.8	36,814	21.4
1981	17,255	19.4	30,450	15.0	44,772	21.6
1982	17,971	4.1	32,886	8.0	52,362	17.0
1983	19,361	7.7	35,670	8.5	58,860	12.4
1984	20,638	6.6	38,286	7.3	64,427	9.5
1985	23,305	12.9	42,191	10.2	72,294	12.2
1986	25,727	10.4	45,782	8.5	77,721	7.5
Growth: 1966-86		3,405		2,928		6,742
Average Annual Rate of Growth 1966-86		19.5		18.6		23.5

Note: All dollar figures are in millions. Expenditure information includes administrative costs as well as vendor payments for medical services. Medicaid figures differ from HCFA 2082 spending data not only because they include administrative costs, but also because they are for each calendar year rather than each fiscal year.

Source: Based on data obtained from the Office of the Actuary, Office of National Health Cost Estimates. Health Care Financing Administration.

While an explanation for the differences in these trends is outside the scope of this report, a number of factors are associated with these trends. Among the most important is the types of services offered by each program, the type of beneficiaries of each program, and the reimbursement methods employed in each program. Medicare provides reimbursement for inpatient hospital care to the aged and certain disabled individuals. There is also limited skilled nursing facility coverage, and home health services coverage and at an individual's option, physician service coverage. In 1986, two-thirds of Medicare spending was for hospital services. Medicaid does provide payments for inpatient hospital services and physician care, but it also reimburses a broader array of covered services. In 1986, inpatient hospital services represented 28 percent of Medicaid spending. A large share of Medicaid beneficiaries are children, roughly 50 percent. The health problems of these children are different from those of the aged and disabled, and they are less likely to use and have relatively expensive inpatient hospital stays (see Appendix B and Appendix C). As will be discussed below, much of Medicaid's growth can be attributed to institutional long-term care spending and spending on intermediate care facilities for the mentally retarded.

In recent years, both Medicare and Medicaid have altered their methods of reimbursement as a way to contain costs. Beginning in fiscal year 1984, Medicare changed its hospital reimbursement methods from a retrospective cost based system to a prospective payment system based on a patient's diagnosis.[16] Physician reimbursements underwent "freezes." Likewise, Medicaid's reimbursement mechanisms have also undergone change (see Chapter IV). For example, many States use some form of a prospective payment

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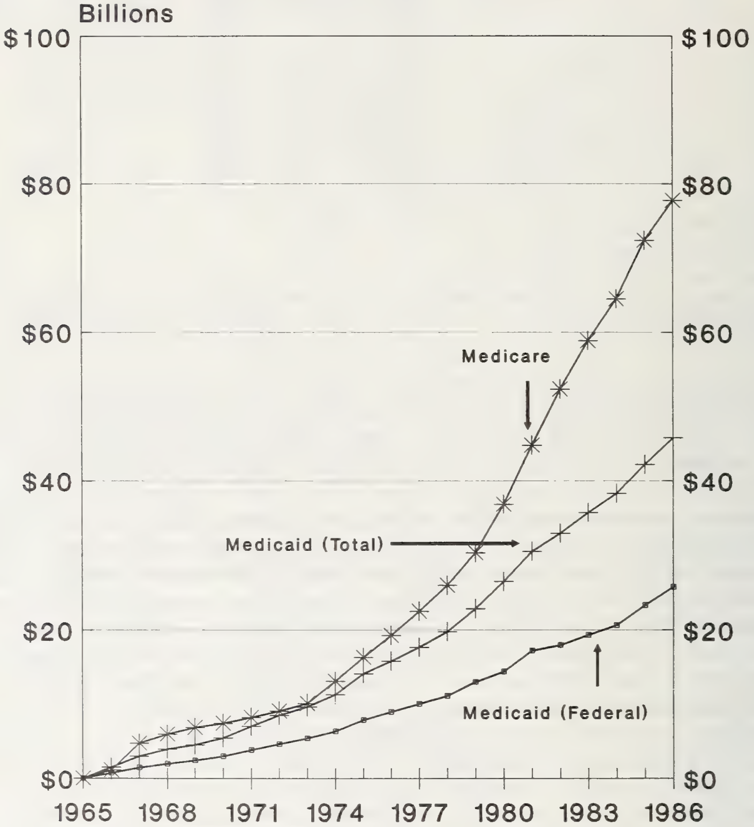
[16] For additional details on Medicare's method of reimbursement see, U.S. House of Representatives, Ways and Means Committee. Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means. 1988 Edition. Committee Print WMCP: 100-29. March 24, 1988. p. 205-263.

Figure I-11
A Comparison of Medicare and Medicaid Expenditures, 1966 - 1986



Source: Office of Actuary, National Health Cost Estimates
Health Care Financing Administration

system for hospital reimbursement. The program has also offered alternative delivery options in hope of containing costs (see Chapter V). In addition, OBRA81 attempted to limit increases in Federal Medicaid spending by making temporary changes in the Medicaid matching formula (Chapter VII).

C. PAYMENTS AND BENEFICIARIES BY SERVICE CATEGORY [17]

1. PAYMENTS

One factor not accounted for in these previous descriptions of spending is the type of services used by Medicaid beneficiaries. The types of services offered under the Medicaid program varies from State to State. As will be discussed in Chapter III, some of these services are required for all beneficiaries; others are optional services and may be limited to certain types of Medicaid enrollees. Since States may limit the amount of care as well as the service type—State decisions about service coverage have a direct effect on the overall trends.

In order to qualify for Federal funds, State Medicaid programs must provide the following mandated services: inpatient and outpatient hospital services, skilled nursing facility services (SNF) for person over 21, home health services for those entitled to SNF care, physician services, lab and x-ray services, early and periodic screening diagnosis and treatment services for children (EPSDT), rural health clinic services, family planning services and nurse midwife services (see Chapter III). In addition, States may provide payments for "optional" services and receive Federal matching payments. Some of the major optional categories include: payments for nursing home care in intermediate care facilities (ICFs), services provided to the mentally retarded in intermediate care facilities (ICF/MR), dental services, prescribed drugs and other services. Some of these optional service categories are offered by almost every State, included in this list are ICF services, prescribed drugs, dental services, and ICF/MR. As a result, some of these optional service categories represent a relatively large share of Medicaid spending (see figure I-12).[18] Table I-7 provides payment information for fiscal year 1975 and fiscal year 1986 for selected service categories.

Table I-7.—MEDICAID PAYMENTS FOR SELECTED MEDICAL SERVICES, FISCAL YEARS 1975 AND 1986

	Fiscal Year 1975		Fiscal Year 1986	
	Payments (in Millions)	Percent of Total	Payments (in Millions)	Percent of Total
Total	$12,242	100.0	$41,027	100.0
Nursing Home Care [1]	4,319	35.3	12,436	30.3
Inpatient Hospital Services	3,779	30.9	11,481	28.0
Physician Services	1,225	10.0	2,548	6.2

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[17] Program spending data for individual service categories is available for the fiscal year 1975 to 1986 period. The analysis of trends in these service categories is limited to this period.

[18] A large number of States providing a particular service category does not guarantee that the service will represent a large share of Medicaid spending. The number of beneficiaries actually using the service as well as each State's reimbursement policy, and limitations of service coverage will affect the aggregate amount of spending in any particular service category.

Table I–7.—MEDICAID PAYMENTS FOR SELECTED MEDICAL SERVICES, FISCAL YEARS 1975 AND 1986—Continued

	Fiscal Year 1975		Fiscal Year 1986	
	Payments (in Millions)	Percent of Total	Payments (in Millions)	Percent of Total
Prescribed Drugs	815	6.7	2,692	6.6
Other Services [2]	689	5.6	2,246	5.5
ICF/MR	380	3.1	5,081	12.4
Outpatient Services	373	3.0	1,983	4.8
Dental Services	339	2.8	532	1.3
Other Practitioners	127	1.0	252	0.6
Lab & X-Ray Service	126	1.0	424	1.0
Home Health Services	70	0.6	1,352	3.3

[1] includes spending for intermediate care facilities as well as skilled nursing facilities.

[2] "Other services" includes payments for rural health clinics, EPSDT, family planning, clinic services, and other care.

Note: All estimates include spending for the States, the District of Columbia, the Virgin Islands and Puerto Rico.
Source: All figures are estimates based on data contained on HCFA form 2082.

The two types of service categories representing the largest share of Medicaid payments are: spending on inpatient hospital care, and spending on long term institutional care. Although these two types of services represent a considerable amount of Medicaid spending (58.3 percent in fiscal year 1986), their share of total program payments has declined.

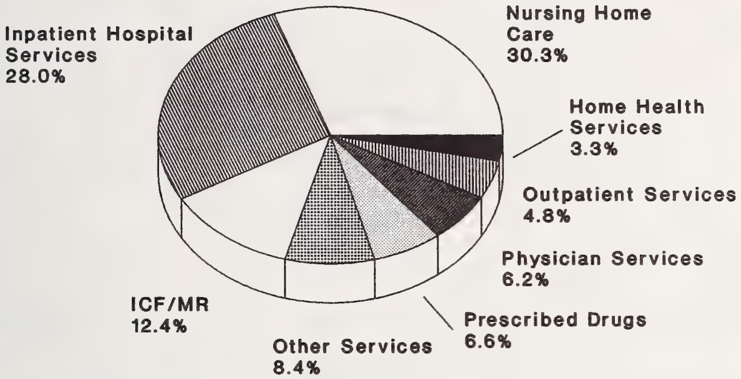
The combined spending for intermediate care facilities and skilled nursing facilities, the two service categories that represent Medicaid's long term care spending in nursing homes, constitutes the largest share of Medicaid payments in any of the 13 years of available spending data. Despite the rapid growth in the elderly population, the primary user of long term care facilities, and the predominant role Medicaid plays in paying for these services (see Appendix C), the increase in Medicaid's institutional long term care spending has not been more rapid than overall program spending increases. In 1975, institutional long term care spending comprised 35.3 percent of all Medicaid payments; by 1986 this spending category's share declined to 30.3 percent of all Medicaid payments.

Spending on inpatient hospital services represents the next largest share of Medicaid spending. Like institutional long term care, its share of Medicaid spending has declined since 1975. In 1975, inpatient hospital care spending represented 30.9 percent of all Medicaid payments; by 1986, it represented 28 percent.

It was other, smaller service categories, that had growth rates that exceeded overall program spending. Two of these services are optional categories: ICF/MR and home health services. The other is a mandated category—hospital outpatient services (see table I–7).

Outpatient services and ICF/MR spending have short term spending patterns that differ from their long term trends. Between 1975 and 1981 spending on outpatient services grew from 3 percent of Medicaid payments to 5.2 percent. However, in 1982 this service category's share of Medicaid spending declined to 4.9 percent and has fluctuated between 4.8 and 4.9 percent over the last four years. Similarly, between 1975 and 1983 spending for services in intermediate care facilities for the mentally retarded grew from 3.1 per-

Figure I-12
Medicaid Payments by Service Category, FY 1986



Source: HCFA form 2082.

cent to 12.6 percent of Medicaid spending. But between 1983 and 1985, this service category's share of Medicaid spending has represented 12.6 percent. In 1986, it declined slightly to 12.4 percent. In contrast, spending on home health services has grown continuously over the entire period from 0.6 to 3.3 percent of Medicaid spending.

Spending on physician services, dental services, and other practitioner services declined as a share of Medicaid payments over this period. Physician services declined from 10 percent in 1975 to 6.2 percent in 1986; dental services from 2.8 to 1.3 percent. These trends may be the result of coverage limitations imposed by States (see chapter III), or a reduction in the number of participating physicians resulting in some beneficiaries substituting outpatient services for physician services (see Appendix G).[19]

Service category shares of the overall spending increases provide another perspective on these payment trends. Between 1975 and 1986, Medicaid spending grew by $28.8 billion. Figure I–13 portrays the share of Medicaid spending selected service categories represented in fiscal year 1975 and fiscal year 1986, as well as the share each service category represented of this $28.8 billion. Three service categories, nursing home care, inpatient hospital services, and ICF/MR services represent 71.3 percent of the increase in program spending over this period. Since nursing home care and inpatient hospital services also represent a large segment of program spending, their large contribution to the spending increase is not unexpected. Comparing the share of program growth to the share of fiscal year 1975 and fiscal year 1986 program spending, the large contribution by ICF/MR is largely the result of the substantial growth in the number of beneficiaries using this service and its cost. In addition, the chart highlights the growing share of Medicaid spending in outpatient services and home health services.

ICF/MR services are an "optional" Medicaid service. These services were first paid for by the Medicaid program in 1972. Every State except Arizona and Wyoming provides payments in this category. Over the period described in this analysis, the number of Medicaid ICF/MR certified beds in public institutions has increased. But, the total number of institutionalized residents has been declining. As a result, Medicaid's share of spending in these public institutions has dramatically increased. Furthermore, expenditure per recipient for ICF/MR has greatly increased. Appendix D provides a more detailed description of ICF/MR services, beneficiary and payment trends.

2. BENEFICIARIES BY SERVICE CATEGORY

Those service categories that represent the largest share of Medicaid spending—inpatient hospital care and long term institutional care—do not have the largest number of users of services. The service categories with the largest number of beneficiaries are: physician services, prescribed drugs, and outpatient services. In 1986,

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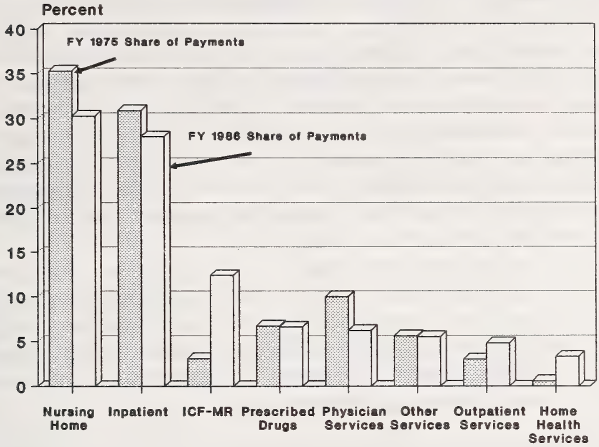
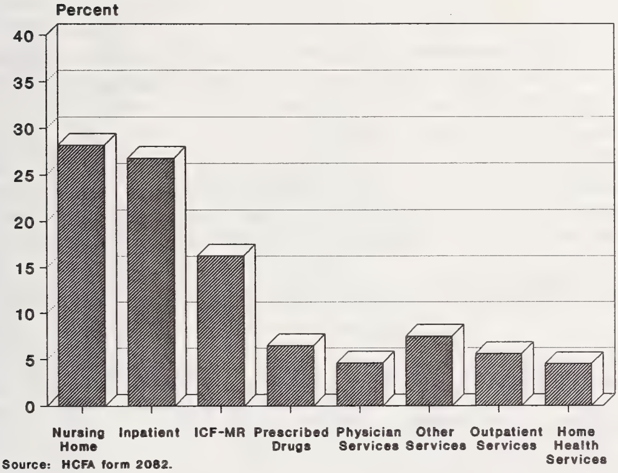
[19] It should not be assumed that the only explanation for changes in share of Medicaid is the substitution of one service for another. Any substitution of one service for another would be associated with the volume of services provided. The noted changes in aggregate spending may not be a result of changes in the volume of services. Rather, one service category may be experiencing higher price increases than another category.

Figure I-13
Composition of Medicaid Payments and Shares of Payment Growth, By Service Categories, FY 1975 - FY 1986



Share of Payment Growth, 1975 - 1986



Source: HCFA form 2082.

nearly 15 million Medicaid beneficiaries used physician services and prescribed drug services; while 11 million used outpatient services. The least used major service category is ICF/MR, with 145 thousand beneficiaries in 1986.

While the overall number of Medicaid beneficiaries has only increased by 2.3 percent since 1975, most individual service categories experienced a substantial gain in the number of beneficiaries (see table I-8). The service categories with the largest percentage increases in beneficiaries include: ICF/MR, home health services, lab and x-ray services and the residual "other" services category. These service beneficiary trends suggest that part of the reason for increased Medicaid spending, despite a relatively constant number of total beneficiaries is that there is greater use of the different services provided by the program.

But, there are some important exceptions to this growth phenomenon; for example, the number of beneficiaries using physician services declined by 2 percent over the 11 year period. Over this same time period, the number of beneficiaries using inpatient hospital services increased at a pace (2.8 percent) that is relatively close to the overall program increases.

Table I-8.—NUMBER OF MEDICAID BENEFICIARIES USING SELECTED MEDICAL SERVICES, FISCAL YEARS 1975 AND 1986

Service Category	Fiscal Year 1975 Beneficiaries (in Thousands)	Fiscal Year 1986 Beneficiaries (in Thousands)	Percentage Change
Total	22,007	22,518	2.3
Nursing Home Care [1]	1,312	1,399	6.6
Inpatient Hospital Services	3,499	3,597	2.8
Physician Services	15,198	14,897	−2.0
Prescribed Drugs	14,155	14,704	3.9
Other Services [2]	5,214	9,336	79.1
ICF/MR	69	145	110.1
Outpatient Services	7,437	10,711	44.0
Dental Services	3,944	5,162	30.9
Other Practitioners	2,673	3,451	29.1
Lab & X-ray Services	4,738	7,122	50.3
Home health Services	343	593	72.9

[1] The number of beneficiaries using either Intermediate Care Facilities or Skilled Nursing Facilities.

[2] Other services include EPSDT, clinic services, family planning services and other care.

Note: Sum of Service categories do not equal total beneficiary count since beneficiaries may use more than one service type. Service categories ranked by share of Medicaid payments in fiscal year 1975. All figures are estimates for the States, the District of Columbia, Puerto Rico and the Virgin Islands.

Source: All figures are estimates based on information contained in HCFA form 2082.

D. PAYMENTS AND BENEFICIARIES BY ELIGIBILITY STATUS

Eligibility rules for the Medicaid program vary from State to State (see Chapter II and Appendix A). While States must cover individuals eligible for the Aid to Families with Dependent Children program (AFDC), and most States cover disabled, blind and aged recipients of the Supplemental Security Income (SSI) program, States have an option to cover additional categories of persons. These optional categories include the medically needy, and other low-income individuals who do not meet all of the eligibility requirements of AFDC or SSI.

Medicaid beneficiaries can be divided into four major eligibility categories: the aged, the disabled and blind, children and adults in families with dependent children, and other Title XIX beneficiaries.[20] Beneficiaries can also be divided into those who are categorically eligible (i.e. in AFDC-eligible families, or SSI recipients) because they are receiving cash assistance payments, those who are categorically eligible not receiving cash assistance payments (i.e. individuals who meet many of the cash assistance program eligibility rules, but for some reason do not actually receive the payments), and those who are eligible because they are medically needy (i.e. they incur substantial out of pocket medical expenses).

1. PAYMENTS BY ELIGIBILITY STATUS

In fiscal year 1986, the largest share of Medicaid payments were spent on the aged (including those eligible for the program because they were medically needy, or receiving Medicaid only but no cash assistance) ($15.1 Billion). Spending on the disabled and blind contributed another $14.9 billion, while spending on adults and children in families with dependent children accounted for $10 billion, other beneficiaries made up the remaining $1 billion in Medicaid spending (see figure I–2).

Since fiscal year 1975, the largest increases in spending by eligibility status has been for those beneficiaries who are 1) permanently and totally disabled; and 2) those individuals who are aged (see table I–9 and figure I–14). The average annual payment growth rate for the disabled over the 11-year period is 15.2 percent; this compares with a growth rate of 12 percent for the aged, and the more moderate 8.1 percent growth rate for children and adults in families with dependent children. The lowest annual growth rate in payments is for other Title XIX beneficiaries (6.6 percent).

Table I–9.—MEDICAID PAYMENTS BY ELIGIBILITY STATUS, FISCAL YEARS 1975–86

[All Dollar Amounts are in Millions]

Fiscal Year	Aged		Blind and Disabled		Children in Dependent Families		Adults in Dependent Families		Other Title XIX Beneficiaries [1]		Total	
	Payments	Annual Percentage Change	Payments	Annual Percentage Change	Payments	Annual Percentage Change	Payments	Annual Percentage Change	Payments	Annual Percentage Change	Payments	Annual Percentage Change
1975	$4,358	....	3,145	....	$2,186	....	$2,062	....	$492	....	$12,242	....
1976	4,910	12.7	3,920	24.6	2,431	11.2	2,288	11.0	542	10.2	14,091	15.1
1977	5,499	12.0	4,883	24.6	2,610	7.4	2,606	13.9	641	18.2	16,239	15.2
1978	6,308	14.7	5,620	15.1	2,748	5.3	2,673	2.6	643	0.3	17,992	10.8
1979	7,046	11.7	6,882	22.5	2,884	5.0	3,021	13.0	638	−0.7	20,472	13.8
1980	8,739	24.0	7,621	10.7	3,123	8.3	3,231	7.0	596	−6.6	23,311	13.9
1981	9,926	13.6	9,455	24.1	3,508	12.3	3,763	16.4	552	−7.3	27,204	16.7
1982	10,739	8.2	10,405	10.1	3,473	−1.0	4,093	8.8	689	24.6	29,399	8.1
1983	11,954	11.3	11,367	9.2	3,836	10.4	4,487	9.6	747	8.6	32,391	10.2
1984	12,815	7.2	11,977	5.4	3,979	3.7	4,420	−1.5	700	−6.3	33,891	4.6
1985	14,096	10.0	13,452	12.3	4,414	11.0	4,746	7.4	798	14.1	37,508	10.7

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[20] The "other" beneficiaries are mostly "Ribicoff Children", i.e. children who except for the AFDC "dependency" criteria would be eligible for Medicaid (see Chapter II).

Table I–9.—MEDICAID PAYMENTS BY ELIGIBILITY STATUS, FISCAL YEARS 1975–86—Continued

[All Dollar Amounts are in Millions]

Fiscal Year	Aged		Blind and Disabled		Children in Dependent Families		Adults in Dependent Families		Other Title XIX Beneficiaries [1]		Total	
	Payments	Annual Percentage Change	Payments	Annual Percentage Change	Payments	Annual Percentage Change	Payments	Annual Percentage Change	Payments	Annual Percentage Change	Payments	Annual Percentage Change
1986........	15,100	7.1	14,924	10.9	5,136	16.3	4,877	2.7	991	24.1	41,027	9.4
Percentage Change 1975–86:		246.5		374.5		134.9		136.5		101.4		235.1
Average Annual Rate of Change 1975–86 (percent):		12.0		15.2		8.1		8.1		6.6		11.6

[1] The "other" category is composed predominantly of children not meeting the statutory definition of "dependent children" (i.e. "Ribicoff Children"). See Chapter II for specific details on this eligibility group. Children in this category would include children living in two-parent families, children living in privately subsidized foster care, or children living in institutions.

Note: All estimates include spending for States, the District of Columbia, the Virgin Islands and Puerto Rico. All dollar amounts are in millions.
Source: All figures are estimates based on data contained on HCFA form 2082.

2. BENEFICIARIES BY ELIGIBILITY STATUS

Table I–10 provides the trends in beneficiaries by eligibility category. The chart points to a number of important dimensions of the program. First, despite the modest increases in the overall number of Medicaid beneficiaries, different eligibility categories experienced some rather large changes. For example, the number of blind and disabled beneficiaries increased by 29 percent between 1975 and 1986. Most of this increase occurred prior to 1981.

Likewise, the number of adults in AFDC units covered by Medicaid increased by one fourth over the time period. This is likely to be a result of two phenomenon. First, the size of AFDC families has been getting smaller.[21] Second, the number of beneficiaries on the AFDC roles who are eligible because of AFDC–UP programs has been increasing over this time period. Both of these trends help to increase the number of adults in the AFDC and Medicaid program.

What seems more striking about the beneficiary data is that the number of aged beneficiaries has actually declined over the time period. This has occurred despite a U.S. population that is getting older, and despite a trend in Medicaid payments that shows long-term care services representing a large component of total Medicaid payments.

A more detailed look at the trend in aged Medicaid beneficiaries shows that the aged who become eligible for the Medicaid program because of receipt of SSI represent a smaller share of the total number of aged beneficiaries than in earlier periods. Figure I–15 portrays the number of aged beneficiaries taking into account their eligibility status.

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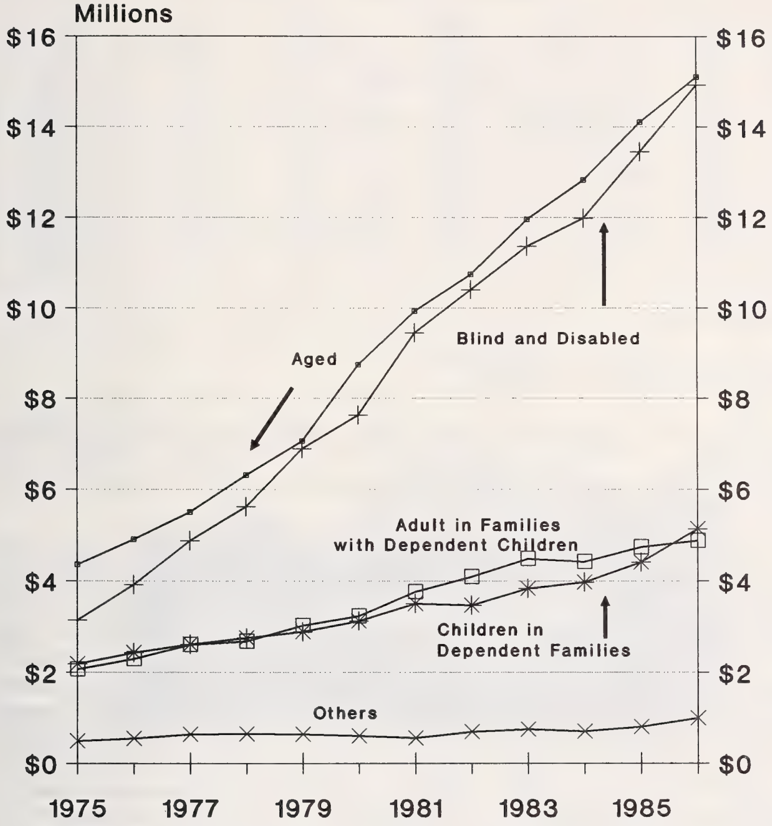
[21] In 1975 the average family size of AFDC recipients was 3.2, in 1986 the average family size was 3.0. At the same time of this decrease in family size, the number of AFDC families was increasing. This combination of an increase in the number of filing units and a decrease in the size of the families results in a shift in the ratio of child to adult AFDC recipients.

Figure I-14
Medicaid Payments by Eligibility Status Fiscal Year 1975 - Fiscal Year 1986



Source: HCFA form 2082.

Table I–10.—BENEFICIARIES BY ELIGIBILITY STATUS, FISCAL YEARS 1975–86

[All Beneficiary Figures are in Thousands]

					Persons in Families with Dependent Children							
Fiscal Year	Aged	Annual Percentage Change	Blind & Disabled	Annual Percentage Change	Children	Annual Percentage Change	Adults	Annual Percentage Change	Others [1]	Annual Percentage Change	Total	Annual Percentage Change
1975	3,615	....	2,464	....	9,598	....	4,529	....	1,800	....	22,007	....
1976	3,612	−0.1	2,669	8.3	9,924	3.4	4,773	5.4	1,836	2.0	22,815	3.7
1977	3,636	0.7	2,802	5.0	9,651	−2.8	4,785	0.3	1,959	6.7	22,832	0.1
1978	3,376	−7.2	2,718	−3.0	9,376	−2.8	4,643	−3.0	1,852	−5.5	21,965	−3.8
1979	3,364	−0.4	2,753	1.3	9,106	−2.9	4,570	−1.6	1,727	−6.7	21,520	−2.0
1980	3,440	2.3	2,911	5.7	9,333	2.5	4,877	6.7	1,500	−13.1	21,605	0.4
1981	3,367	−2.1	3,079	5.8	9,581	2.7	5,187	6.4	1,364	−9.1	21,980	1.7
1982	3,240	−3.8	2,891	−6.1	9,563	−0.2	5,356	3.3	1,434	5.1	21,603	−1.7
1983	3,372	4.1	2,921	1.0	9,535	−0.3	5,592	4.4	1,129	−21.3	21,554	−0.2
1984	3,238	−4.0	2,913	−0.3	9,684	1.6	5,600	0.1	1,187	5.1	21,607	0.2
1985	3,061	−5.5	3,017	3.6	9,752	0.7	5,518	−1.5	1,214	2.3	21,808	0.9
1986	3,140	2.6	3,181	5.4	10,031	2.9	5,647	2.3	1,366	12.5	22,518	3.3
Percent Change 1975–86:		−13.1		29.0		4.5		24.7		−24.1		2.3
Average Annual Rate of Change 1975–86 (percent):		−1.3		2.3		0.4		2.0		−2.5		0.2

[1] The "other" category is composed predominantly of children not meeting the statutory definition of "dependent children" (i.e. "Ribicoff Children"). See Chapter II for specific details on this eligiblity group. Included in this group are children in two-parent families, children in institutions, and others.

Note: All beneficiary figures are in thousands. All figures are estimates for the States, the District of Columbia, Puerto Rico and the Virgin Islands.

Source: All figures are estimates based on data contained on HCFA form 2082.

The number of aged beneficiaries eligible for Medicaid as a result of receipt of SSI actually declined over this period. In 1975, aged beneficiaries who also received SSI totalled 2.5 million, by 1986 these beneficiaries totalled 1.7 million. This represents a 31.7 percent decrease in the number of aged beneficiaries who are eligible because of receipt of SSI. This corresponds to trends in the overall number of aged SSI recipients. There are likely to be two reasons for this phenomenon. First, the increase in Social Security benefits, and private pensions may account for fewer of the aged qualifying for SSI. These individuals may have income levels that exceed the income limits associated with eligibility for the SSI program.[22] The other possible explanation stems from the asset test that is part of SSI eligibility rules. In 1988, SSI eligibility is limited to qualified persons who have countable assets of less than $1,900 or $2,850 in the case of a married couple. Some analysts have argued that as the aged have higher income and assets, fewer are able to meet these eligibility standards. The number of aged beneficiaries eligible for Medicaid because of receipt of SSI comes at a time when aged beneficiaries who are medically needy has increased.

Comparing tables I–9 and I–10 highlights a constancy about the program. The aged, disabled, and blind represent a disproportionately large share of program spending, when compared to their share of beneficiaries. This differential stems from their use of

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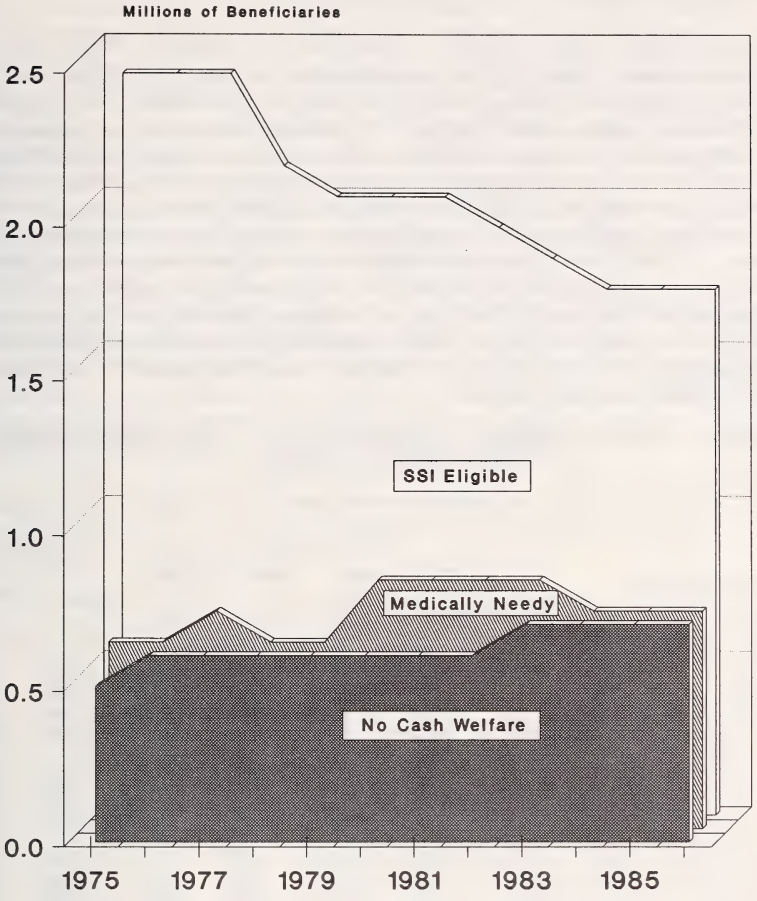
[22] See HCFA, "Grants and Contracts Report: A Decade of Medicaid Experience, Fiscal Years 1973 through 1982". HCFA, Office of Research and Demonstrations, Baltimore, MD. Sept. 1985. p. 25.

Figure I-15
Aged Beneficiaries by Eligibility Status, 1975 - 1986



Source: HCFA form 2082

more expensive medical services, as well as the likelihood of their being more in need of these services than the other eligibility groups (see Appendix B and Appendix C).

3. PAYMENTS BY RECEIPT OF CASH ASSISTANCE PAYMENTS

The share of spending on beneficiaries who are eligible for the Medicaid program because of receipt of cash assistance payments has declined since 1975. Table I–11 shows the spending trends for the categorically needy receiving cash assistance payments, the categorically needy not receiving cash assistance payments, and the medically needy. In 1975, 59 percent of all Medicaid payments went for services rendered to beneficiaries with cash assistance payments, by 1982 this share was reduced to 54 percent, and in 1986 it equaled 51 percent. This reduction in spending on cash assistance beneficiaries has been offset by increased spending for the categorically needy not receiving cash assistance payments. Generally, spending on the medically needy has represented about 27 percent of total Medicaid spending.

Table I–11.—MEDICAID PAYMENTS BY BENEFICIARY RECEIPT OF CASH ASSISTANCE PAYMENTS, FISCAL YEARS 1975 TO 1986

[All Dollar Amounts are in Millions]

Fiscal Year	Categorically Needy				Medically Needy	
	With Cash Assistance		Without Cash Assistance			
	Payments	Percent of Total	Payments	Percent of Total	Payments	Percent of Total
1975	$7,188	58.7	$1,753	14.3	$3,301	27.0
1976	8,154	57.9	2,088	14.8	3,848	27.3
1977	9,577	59.0	2,465	15.2	4,198	25.8
1978	10,160	56.5	3,101	17.2	4,731	26.3
1979	11,281	55.1	3,857	18.8	5,334	26.1
1980	12,344	53.0	3,779	16.2	7,188	30.8
1981	14,534	53.4	4,736	17.4	7,935	29.2
1982	15,862	54.0	5,410	18.4	8,127	27.6
1983	17,112	52.8	6,409	19.8	8,870	27.4
1984	17,564	51.8	7,033	20.8	9,294	27.4
1985	19,316	51.5	7,832	20.9	10,359	27.6
1986	21,039	51.3	8,753	21.3	11,235	27.4

Note: All dollar amounts are in millions. Estimates include spending for the States, the District of Columbia, the Virgin Islands and Puerto Rico. Payments for individuals who are categorically needy receiving cash assistance payments are for individuals who qualify for Medicaid by virtue of AFDC or SSI receipt. Payments for the categorically needy without cash assistance are for those individuals who may not qualify for these programs, but because of optional or other mandated eligibility rules still qualify for Medicaid. Payments for the Medically Needy are payments for those individuals who qualify for Medicaid as a result of high out of pocket medical costs. See chapter II for the specific definitions for each of these categories.

Source: All figures are estimates based on data contained on HCFA forms 2082.

This reduction in spending on those receiving cash assistance is likely to be the result of two trends: 1.) over time there has been a smaller number of aged cash assistance beneficiaries becoming eligible for the program; and 2.) there has been substantially higher rates of growth in spending for disabled Medicaid beneficiaries not receiving cash assistance payments than other eligibility categories.

Aged beneficiaries receiving cash assistance have one of the higher payments per beneficiary amounts in the program, a reduction in their number, all other things being equal will reduce total

Medicaid payments going to those eligible for the program because of receipt of cash assistance payments.

4. BENEFICIARIES BY RECEIPT OF CASH ASSISTANCE PAYMENTS

Since 1975, individuals receiving cash assistance payments have accounted for about three-fourths of all Medicaid beneficiaries.[23] While total beneficiary counts increased since 1975 by 2.3 percent, the number of beneficiaries receiving cash assistance has declined slightly, by .5 percent (see table I-12). In contrast, the number of beneficiaries who are categorically eligible, but not receiving cash assistance payments has increased dramatically. Between 1975 and 1986 the number of beneficiaries categorically eligible without cash assistance payments increased by 115 percent.

This increase in the number of Medicaid beneficiaries who do not receive cash welfare is partly the result of Congress loosening the ties between welfare eligibility and Medicaid eligibility. A number of legislative changes mandated broader coverage of individuals not receiving cash assistance and gave States greater flexibility in their optional coverage of some noncash welfare groups. Chapters II and VIII provide the details of these changes.

Table I-12.—BENEFICIARIES BY RECEIPT OF CASH ASSISTANCE PAYMENTS, FISCAL YEARS 1975 TO 1986

Fiscal Year [1]	Categorically Needy				Medically Needy	
	With Cash Assistance		Without Cash Assistance			
	Beneficiaries	Annual Percentage Change	Beneficiaries	Annual Percentage Change	Beneficiaries	Annual Percentage Change
1975	16,678		1,390		3,939	
1976	17,222	3.3	1,564	12.5	4,028	2.3
1977	17,067	-0.9	1,641	4.9	4,124	2.4
1978	16,423	-3.8	1,697	3.4	3,845	-6.8
1979	16,056	-2.2	1,793	5.7	3,672	-4.5
1980	16,497	2.7	1,559	-13.1	3,832	4.4
1981	16,872	2.3	1,793	15.0	3,700	-3.4
1982	16,594	-1.6	2,037	13.6	3,605	-2.6
1983	16,519	-0.5	2,273	11.6	3,582	-0.6
1984	16,478	-0.2	2,536	11.6	3,454	-3.6
1985	16,459	-0.1	2,610	2.9	3,413	-1.2
1986	16,596	0.8	2,983	14.3	3,656	7.1
Percentage Change 1975-86		-.5		114.6		-7.2
Average Annual Rate of Change 1975-86 (percent)		-.05		7.2		-.7

Note: All figures are estimates that include beneficiaries in the States, the District of Columbia, the Virgin Islands, and Puerto Rico. Individuals who are categorically needy receiving cash assistance payments are individuals who qualify for Medicaid by virtue of AFDC or SSI receipt. Individuals who are categorically needy without cash assistance are individuals who may not qualify for these cash assistance programs, but because of optional or mandated eligibility rules still qualify for Medicaid. Medically Needy individuals qualify for Medicaid as a result of high out of pocket medical expenses. See Chapter II for the specific definitions for each of these categories.

Source: All figures are estimates based on data contained in HCFA forms 2082.

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[23] This percentage is based on all Medicaid beneficiaries. Since 1981 this is an unduplicated total count. Some people may be counted in more than one eligibility category at different times during the year. As a result, the sum of the individual eligibility categories exceeds the total category. This unduplicated counted is about 3 percent less than the sum of these individual categories.

E. Payments and Beneficiaries by State

In fiscal year 1986, Medicaid spending in eight States represented over 57 percent of total program spending. These eight States are: New York, California, Ohio, Pennsylvania, Michigan, Illinois, Massachusetts, and Texas. (See table I-13). Spending increases in these eight States also represented over 57 percent of the total increase in spending between 1975 and 1986.

Table I–13.—STATE BY STATE MEDICAID PAYMENTS, SHARE OF TOTAL PAYMENTS, AND PERCENTAGE INCREASE, FISCAL YEARS 1975–86

State	Fiscal Year 1975		Fiscal Year 1986		Fiscal Years 1975–86 Percentage Increase
	Payments	Share of Total	Payments	Share of Total	
Total	$12,242	100.0	$41,027	100.0	235.1
New York	2,955	24.1	8,223	20.0	178.3
California	1,491	12.2	4,405	10.7	195.4
Pennsylvania	709	5.8	1,993	4.9	181.0
Illinois	682	5.6	1,675	4.1	145.5
Michigan	621	5.1	1,768	4.3	184.8
Massachusetts	494	4.0	1,665	4.1	237.2
Texas	461	3.8	1,628	4.0	253.5
New Jersey	366	3.0	1,281	3.1	249.7
Wisconsin	361	3.0	920	2.2	154.6
Ohio	350	2.9	2,050	5.0	484.8
Georgia	256	2.1	818	2.0	219.2
Minnesota	251	2.1	1,044	2.5	315.9
Washington	176	1.4	625	1.5	255.2
Florida	173	1.4	1,003	2.4	481.1
Indiana	172	1.4	828	2.0	380.4
North Carolina	163	1.3	751	1.8	359.9
Connecticut	161	1.3	675	1.6	319.2
Virginia	160	1.3	595	1.4	272.5
Maryland	159	1.3	680	1.7	328.3
Louisiana	143	1.2	780	1.9	444.0
Oklahoma	141	1.1	422	1.0	200.3
Alabama	131	1.1	410	1.0	211.9
Tennessee	123	1.0	714	1.7	482.2
Puerto Rico	113	0.9	156	0.4	37.9
Kansas	102	0.8	239	0.6	134.0
Kentucky	100	0.8	537	1.3	435.1
Missouri	99	0.8	556	1.4	459.8
Colorado	98	0.8	300	0.7	206.2
Mississippi	95	0.8	317	0.8	234.6
District of Columbia	94	0.8	201	0.5	113.9
Arkansas	93	0.8	434	1.1	366.5
Iowa	82	0.7	374	0.9	358.3
South Carolina	76	0.6	394	1.0	420.5
Oregon	74	0.6	260	0.6	251.2
Rhode Island	72	0.6	263	0.6	264.5
Maine	60	0.5	283	0.7	368.1
Nebraska	54	0.4	188	0.5	245.6
Hawaii	37	0.3	137	0.3	269.9
Vermont	31	0.3	95	0.2	202.3
Utah	31	0.2	140	0.3	359.8
Montana	29	0.2	112	0.3	284.9
New Mexico	29	0.2	165	0.4	468.9
West Virginia	29	0.2	201	0.5	594.4

Table I–13.—STATE BY STATE MEDICAID PAYMENTS, SHARE OF TOTAL PAYMENTS, AND PERCENTAGE INCREASE, FISCAL YEARS 1975–86—Continued

State	Fiscal Year 1975		Fiscal Year 1986		Fiscal Years 1975–86 Percentage Increase
	Payments	Share of Total	Payments	Share of Total	
New Hampshire	28	0.2	133	0.3	372.2
Idaho	24	0.2	85	0.2	249.4
North Dakota	23	0.2	122	0.3	418.5
South Dakota	22	0.2	103	0.3	373.1
Nevada	16	0.1	79	0.2	390.6
Delaware	15	0.1	79	0.2	440.6
Alaska	9	0.1	85	0.2	899.9
Wyoming	5	0.0	33	0.1	571.9
Virgin Islands	2	0.0	4	0.0	86.6

Note: All dollar amounts are in millions. States are ranked based on their share of fiscal year 1975 Medicaid payments.
Source: All figures are estimates based on data contained on HCFA form 2082.

The share of State spending is influenced by State population, and the actual number of Medicaid beneficiaries in the State (see table I–14). In 1986 a slightly different set of seven States and Puerto Rico made up 57 percent of program beneficiaries. These States include: California, New York, Michigan, Pennsylvania, Ohio, Illinois and Texas (Massachusetts ranked eleventh in the number of Medicaid beneficiaries).

Table I–14.—STATE BY STATE MEDICAID BENEFICIARIES, SHARE OF TOTAL BENEFICIARIES, AND PERCENTAGE INCREASE, FISCAL YEARS 1975–86

State	Fiscal Year 1975		Fiscal Year 1986		Fiscal Years 1975–86 Percentage Increase
	Beneficiaries	Share of Total	Beneficiaries	Share of Total	
Total	22,006,584	100.00	22,517,663	100.00	2.32
California	3,344,341	15.20	3,466,100	15.39	3.64
New York	2,574,604	11.70	2,322,628	10.31	−9.79
Puerto Rico	1,662,601	7.56	1,761,833	7.82	5.97
Illinois	1,599,960	7.27	1,063,541	4.72	−33.53
Pennsylvania	1,331,230	6.05	1,099,321	4.88	−17.42
Michigan	954,632	4.34	1,119,724	4.97	17.29
Ohio	809,259	3.68	1,078,851	4.79	33.31
Texas	728,698	3.31	878,985	3.90	20.62
New Jersey	623,189	2.83	581,211	2.58	−6.74
Massachusetts	589,848	2.68	528,931	2.35	−10.33
Georgia	516,325	2.35	483,514	2.15	−6.35
Wisconsin	418,562	1.90	409,401	1.82	−2.19
Louisiana	396,952	1.80	446,423	1.98	12.46
Florida	385,904	1.75	587,615	2.61	52.27
Missouri	360,301	1.64	359,942	1.60	−0.10
Kentucky	356,754	1.62	414,859	1.84	16.29
Maryland	345,051	1.57	323,404	1.44	−6.27
North Carolina	329,050	1.50	378,218	1.68	14.94
Alabama	323,248	1.47	316,411	1.41	−2.12
Tennessee	319,600	1.45	394,673	1.75	23.49
Virginia	312,437	1.42	314,190	1.40	0.56
Washington	288,280	1.31	357,879	1.59	24.14
Mississippi	287,196	1.31	318,871	1.42	11.03
South Carolina	266,053	1.21	262,136	1.16	−1.47

Table I–14.—STATE BY STATE MEDICAID BENEFICIARIES, SHARE OF TOTAL BENEFICIARIES, AND PERCENTAGE INCREASE, FISCAL YEARS 1975–86—Continued

State	Fiscal Year 1975		Fiscal Year 1986		Fiscal Years 1975–86 Percentage Increase
	Beneficiaries	Share of Total	Beneficiaries	Share of Total	
Minnesota	245,335	1.11	344,459	1.53	40.40
Indiana	242,184	1.10	297,755	1.32	22.95
Oklahoma	216,978	0.99	242,339	1.08	11.69
Connecticut	192,271	0.87	216,643	0.96	12.68
Arkansas	184,197	0.84	203,342	0.90	10.39
Oregon	169,049	0.77	162,524	0.72	−3.86
Kansas	155,298	0.71	131,046	0.58	−15.62
Colorado	151,415	0.69	149,030	0.66	−1.58
District of Columbia	146,988	0.67	98,020	0.44	−33.31
Iowa	143,335	0.65	221,905	0.99	54.82
West Virgina	125,099	0.57	211,174	0.94	68.81
Maine	121,554	0.55	125,076	0.56	2.90
Rhode Island	110,817	0.50	97,203	0.43	−12.29
Hawaii	109,281	0.50	88,901	0.39	−18.65
New Mexico	76,079	0.35	91,846	0.41	20.72
Nebraska	69,624	0.32	102,051	0.45	46.57
Utah	55,804	0.25	75,622	0.34	35.51
New Hampshire	50,080	0.23	35,350	0.16	−29.41
Vermont	48,839	0.22	50,012	0.22	2.40
Delaware	48,802	0.22	39,270	0.17	−19.53
Montana	44,664	0.20	52,211	0.23	16.90
South Dakota	41,966	0.19	36,651	0.16	−12.67
Idaho	38,733	0.18	40,291	0.18	4.02
North Dakota	26,828	0.12	40,150	0.18	49.66
Virgin Islands	23,614	0.11	13,857	0.06	−41.32
Nevada	23,333	0.11	32,545	0.14	39.48
Wyoming	10,572	0.05	21,009	0.09	98.72
Alaska	9,770	0.04	28,720	0.13	193.96

Note: States are ranked based on their share of fiscal year 1975 beneficiaries.
Source: All figures are estimates based on data contained on HCFA form 2082.

But, the State beneficiary figures do not account for all of the spending variation between States. Some States' Medicaid spending is relatively large when compared to their share of beneficiaries. For example, New York's share of total payments is about twice their share of total beneficiaries. Conversely, California represents 11 percent of Medicaid payments, and 15 percent of total beneficiaries. These differentials are the likely result of several factors: the type of services covered by Medicaid within the State (see Chapter III), the reimbursement policies for those services used by the State (see Chapter IV), and the State eligibility criteria used (see Chapter II).

Except for Massachusetts, all of the large spending States experienced growth in total Medicaid spending that was lower than overall program growth between fiscal year 1975 and fiscal year 1986. Most other States experienced rates of growth that were much higher than the overall average. As a result, the top seven spending States' share of Medicaid spending declined slightly, from 60 percent to 57 percent.

Table I–14 highlights another aspect of the Medicaid program. While the overall number of Medicaid beneficiaries moderately grew between fiscal year 1975 and fiscal year 1986, there was no simple pattern in State beneficiary counts. Thirty States and Puerto Rico experienced increases in the number of Medicaid beneficiaries, while twenty States, the District of Columbia and the Virgin Islands experienced decreases. In some instances the change between fiscal year 1975 and fiscal year 1986 was large:

- Illinois beneficiary numbers declined by 34 percent, the District of Columbia's beneficiaries declined by 33 percent, the Virgin Islands by 41 percent;
- Florida's beneficiaries increased by 52 percent, Iowa by 55 percent, West Virginia by 69 percent, Wyoming by 99 percent, and Alaska by 194 percent.

The reasons for this variation in State-by-State Medicaid spending and beneficiary change is outside the scope of this study. It should be noted that it is difficult to fully understand the implication of these State-by-State changes without additional information on the demographic, economic, and medical care service system changes within each State.[24]

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[24] A number of analyses do attempt to explain the State by State variation highlighted in tables I-13 and I-14. See U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Research and Demonstrations, "A Decade of Medicaid Experience, Fiscal Years 1973 through 1982" Grants and Contracts Report, September 1985.

CHAPTER II. ELIGIBILITY [1]

SUMMARY

The Medicaid program is intended to provide basic medical coverage for certain groups of low income persons. The requirements of Federal law coupled with individual State decisions in structuring their programs have produced a program which offers coverage to less than half of the population with incomes below the Federal poverty line. At the same time, some individuals (primarily nursing home residents) with incomes above this poverty threshold are able to establish eligibility.[2]

Federal law places certain limitations on the categories of individuals who can be covered. Since its enactment in 1965, eligibility under Medicaid has generally been linked to actual or potential receipt of cash assistance under a welfare program. Thus, eligible individuals have to meet the welfare definitions of age, blindness, disability, or membership in a family with dependent children where one parent is absent, incapacitated, or (in some States) unemployed. This has had several effects on the population potentially program eligible. First, persons who do not fall into one of the welfare categories generally are not eligible for Medicaid, regardless of their income level. Thus, singles and childless couples who are not aged or disabled cannot be covered. Further, two-parent families with children cannot be covered unless the principal breadwinner is unemployed and the family resides in a State covering this population group.

Second, the link to welfare means that persons who fall into one of the requisite coverage groups also have to meet specified income and resource criteria which vary by State. Automatic coverage is generally limited to persons with incomes and resources sufficiently low to qualify them for welfare payments. Welfare levels are generally lower than the Federal poverty line. Further, the welfare levels for families and children are generally below those for the aged and disabled. This disparity may increase over time since the levels for the aged and disabled are increased automatically each year (except in a few States) while those for families and children are not.

The link to cash assistance has been the primary, but not the only, way to establish Medicaid eligibility. States also have had the option of providing coverage to children under age 21 who meet the requisite income and resource requirements but do not meet the definition of dependent child, for example they are in a two-parent family. Recent legislation moved further from basing Medicaid eligibility on actual or potential receipt of cash assistance. States are now required to cover pregnant women and to phase-in coverage of children under age 7 who meet the State's income and resource requirements regardless of family composition. Further, beginning in 1987, States have had the option of extending coverage to certain target groups with incomes below the Federal poverty line. Beginning in 1989, they will be required to phase-in coverage for certain of these groups.

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[1] This chapter was written by Jennifer O'Sullivan.

[2] See appendix A for a discussion of the relationship between Medicaid coverage and poverty.

Federal requirements for program coverage are not the only determinants of Medicaid eligibility. A second set of factors are the decisions made on the part of individual States. First, decisions regarding where States set income levels for cash programs will also affect the size of their Medicaid programs. In fact, the cost consequences may be greater for Medicaid than for the cash assistance programs. Second, within Federal guidelines, States have considerable leeway in establishing Medicaid eligibility criteria. Thus individuals in similar situations may be automatically eligible for coverage in one State, be required to assume a certain portion of their expenses before they can gain coverage in a second State and not be eligible at all in a third State.

All States do however provide some mechanism whereby some of their nursing home population, which would not otherwise be eligible for coverage may be eligible for protection, generally after spending a portion of their incomes and/or resources on medical care. Once these individuals gain eligibility, most of their income will be applied to the cost of their care. Many of these institutionalized persons were previously middle income rather than low income individuals.

This chapter outlines Medicaid eligibility criteria and highlights interstate variations in coverage requirements. There are two broad categories of eligibility under Medicaid: "categorically needy" and "medically needy." In 1986, over four-fifths of beneficiaries qualified as categorically needy.[3] All States are required to cover certain categorically needy persons (mandatory categorically needy). In general, these are persons receiving assistance under the Aid to Families with Dependent Children (AFDC) program or the Federal Supplemental Security Income (SSI) program for the aged, blind, and disabled. States have the option of limiting coverage of SSI recipients by requiring them to meet more restrictive eligibility standards that were in effect on January 1, 1972 (before implementation of SSI). States choosing the more restrictive criteria must allow applicants to "spenddown", i.e. deduct medical expenses from income in determining eligibility.

States are also required to cover all pregnant women and phase-in coverage of children under age 7 (or at State option, age 8) born after September 30, 1983; these women and children must meet their State's AFDC income and resource requirements.

States may also cover additional persons as categorically needy (optional categorically needy). These may include children whose family income and resources are below the AFDC standard, but whose age is above that for mandated coverage. A State covering this group must provide coverage for all or reasonable categories of children under a maximum age set by the State, which may be either 18, 19, 20, or 21. States may also extend optional categorically needy protection to persons in institutions with incomes below a specified amount not exceeding 300 percent of the SSI payment level.

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[3] See chapter IX for fiscal year 1986 data on program beneficiaries and expenditures.

States may also elect to cover the medically needy under their programs. These are persons whose income and/or resources are in excess of that entitling them to categorically needy coverage. Persons eligible for medically needy coverage are those who: (a) meet the non-financial standards for categorical eligibility (such as age or being a member of a family with dependent children); and (b) whose income and resources, after deducting incurred medical expenses falls below the medically needy standards. The medically needy income standard cannot exceed 133⅓ percent of the maximum AFDC payment for the same sized family.

As noted, recent legislation allows States to extend Medicaid coverage to certain target groups with incomes between the existing State eligibility standard and a State-defined level at or below the Federal poverty line. The first target group is pregnant women, infants, and children under age 8 born on or after September 30, 1983. Beginning July 1, 1988, this group could be expanded to include pregnant women and infants up to age 1 with incomes below 185 percent of poverty. The second target group is elderly and disabled persons. For this second target group, States may either provide full Medicaid coverage or, alternatively, just cover Medicare cost-sharing expenses.

Beginning in 1989, States will be required to phase-in protection for some members of these target groups whose coverge was previously optional. The Medicare Catastrophic Coverage Act (Public Law 100–360) mandates States to phase-in over a 2-year period, beginning July 1989, Medicaid coverage for pregnant women and infants below the poverty line. It also mandates States to phase-in over 4 years, beginning January 1, 1989, payment of Medicare cost-sharing charges on behalf of the elderly and disabled below the poverty line.

Section I of this chapter discusses requirements relating to coverage of the categorically needy. It contains a discussion of mandatory and optional coverage of families and children; a similar discussion is provided with respect to coverage of the so-called adult categories (i.e., the aged, blind, and disabled). Section II discusses requirements relating to coverage of the medically needy. Section III discusses optional and mandatory coverage of specified target groups. Section IV highlights additional factors considered in the eligibility process including treatment of income and resources when one member of a couple is institutionalized, transfer of assets, and liens. Section V discusses additional eligibility issues including citizenship, residence and coverage for the homeless.[4]

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[4] See Chapter VI for a description of the eligibility determination process.

I. CATEGORICALLY NEEDY

All States[5] cover the categorically needy under their Medicaid programs. Generally, these are all AFDC and most SSI recipients. States are given certain options with respect to coverage of the SSI population.

A. Coverage of Families and Children

1. MANDATORY COVERAGE FOR AFDC RECIPIENTS

A State is required to cover under Medicaid all persons receiving cash payments under its AFDC program.[6] AFDC payments are made to families with children[7] where one parent is absent from the home continuously, incapacitated, or dead. States also have the option of providing AFDC (and therefore Medicaid coverage) to families with children where the principal breadwinner is unemployed; this is known as the Aid to Families with Dependent Children Unemployed Parent (AFDC–UP) program. Twenty-seven States (including D.C.) and Guam have an AFDC–UP program. (See table II–1.)

Table II–1.—STATE COVERAGE OF AFDC–UP FAMILIES, DECEMBER 1986

State	AFDC cash and Medicaid	Medicaid only
California	X	
Connecticut	X	
Delaware	X	
District of Columbia	X	
Florida		X
Georgia		X
Guam	X	
Hawaii	X	
Illinois	X	
Iowa	X	
Kansas	X	
Kentucky		X
Louisiana		X
Maine	X	
Maryland	X	
Massachusetts	[1] X	[1] X
Michigan	X	
Minnesota	X	
Missouri	X	
Montana	X	
Nebraska	X	
New Jersey	X	
New York	X	
Ohio	X	

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[5] Arizona does not operate a traditional Medicaid program. Instead, on October 1, 1982, it began implementation of a demonstration project, using Federal matching funds, under which acute care services are provided to the indigent, primarily on a prepaid basis. See appendix E for a discussion of the Arizona program.

[6] For further discussion of the AFDC program see: U.S. Congress, House Committee on Ways and Means. Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means. Committee Print, WMCP: 100–29. U.S. Govt. Print. Off. March 24, 1988.

[7] The AFDC definition of dependent children generally limits coverage to persons under 18, or in certain instances, under age 19.

Table II–1.—STATE COVERAGE OF AFDC–UP FAMILIES, DECEMBER 1986—Continued

State	AFDC cash and Medicaid	Medicaid only
Oregon	X	
Pennsylvania	X	
Rhode Island	X	
South Carolina	X	
Vermont	X	
Washington	X	
West Virginia	X	
Wisconsin	X	
Totals	28	[2] 4

[1] AFDC cash and Medicaid provided for those under 19; Medicaid only for those under 21.
[2] Massachusetts is included in the total of States providing AFDC cash and Medicaid.

Source: National Governors' Association. State Medicaid Program Center. A Catalogue of State Medicaid Program Changes: 1986. 1988. p.79

State-established income criteria for AFDC (and therefore mandatory Medicaid coverage) differ markedly between the States. Under AFDC, each State establishes a "need standard" and a "payment standard" (which may be equal to or lower than the need standard); these standards are adjusted by family size. To receive AFDC payments, a family must pass two income tests, a gross income test and a countable income test. Families with gross incomes that exceed 185 percent of the State's need standard are ineligible for AFDC. Benefits are computed by subtracting countable income (i.e., gross income less certain specified amounts known as disregards) from the payment standard. Table II–2 shows, by State, the maximum monthly benefit applicable for two, three, and four person families as of January 1988. For 3-person families with no other income this ranged from $118 in Alabama to $779 in Alaska. Because specified amounts of personal income are disregarded in determining eligibility for AFDC, a person or family with income which exceeds the maximum benefit may still be eligible for cash assistance and therefore Medicaid. (See appendix A.) In contrast to the Federal SSI program, AFDC income levels are not increased automatically each year.

Table II–2.—AFDC MAXIMUM MONTHLY BENEFIT, BY FAMILY SIZE, JANUARY 1, 1988

State	Family size		
	Two	Three	Four
Alabama	$88	$118	$147
Alaska	692	779	866
Arizona	233	293	353
Arkansas	162	202	238
California	511	633	753
Colorado	280	356	432
Connecticut	485	601	701
Delaware	236	319	374
District of Columbia	298	379	463
Florida	211	275	324
Georgia	220	263	310
Hawaii	429	515	600
Idaho	245	304	344

Table II-2.—AFDC MAXIMUM MONTHLY BENEFIT, BY FAMILY SIZE, JANUARY 1, 1988—Continued

State	Family size		
	Two	Three	Four
Illinois	250	342	386
Indiana	229	288	346
Iowa	322	381	443
Kansas	338	409	470
Kentucky	179	207	259
Louisiana	138	190	234
Maine	310	416	522
Maryland	280	359	432
Massachusetts	422	510	595
Michigan (Washtenaw County)	474	558	659
Michigan (Wayne County)	444	528	629
Minnesota	437	532	621
Mississippi	96	120	144
Missouri	226	282	330
Montana	286	359	433
Nebraska	280	350	420
Nevada	266	325	384
New Hampshire	424	486	541
New Jersey	322	424	488
New Mexico	210	264	317
New York (Suffolk County)	547	665	775
New York (New York City)	439	539	638
North Carolina	231	266	291
North Dakota	301	371	454
Ohio	253	309	382
Oklahoma	240	310	384
Oregon	352	412	501
Pennsylvania	315	402	490
Rhode Island	407	503	574
South Carolina	158	200	240
South Dakota	323	366	408
Tennessee	122	159	194
Texas	158	184	221
Utah	301	376	439
Vermont	505	603	676
Virginia	294	354	410
Washington	397	492	578
West Virginia	201	249	312
Wisconsin	440	517	617
Wyoming	320	360	390
Guam	205	265	310
Puerto Rico	66	90	114
Virgin Islands	126	171	215

Source: Table prepared by Congressional Research Service on the basis of a telephone survey of the States.

AFDC applicants meeting the income criteria are also required to meet resource criteria. By Federal law and regulation, the resource limit for real and personal property cannot exceed $1,000 per family unit. The State must exclude from this calculation the family's home (of any value) and up to $1,500 equity value in an automobile. In addition, States are permitted, but not required, to exclude basic maintenance items essential to day to day living, such as clothing and furniture.

See Appendix A for a discussion of the relationship between eligibility levels and poverty.

2. MANDATORY COVERAGE OF ADDITIONAL PERSONS

An individual who increases her (or his) income from employment faces not only the loss of AFDC but also the potential loss of Medicaid coverage. For certain individuals and their families, the loss of Medicaid coverage may serve as a greater work disincentive than the loss of cash payments. In order to lessen this disincentive, the law contains the following transitional coverage provisions.

—*Families Losing AFDC Because of Employment.* Medicaid coverage must be extended for 4 months to certain families whose cash assistance has been terminated. This extension applies to families who received AFDC for at least 3 of the preceding 6 months and who lost coverage due to increased income from or increased hours of employment.

—*Families Losing AFDC Because Earned Income Disregard Provisions Do Not Apply.* AFDC countable income is gross income less certain disregards. States are required to disregard $30 of earned income per month in the first 12 months and one-third of the rest during the first 4 months in any 1 year period.

States must extend Medicaid coverage for 9 months to families losing AFDC because they no longer qualify for the 12-month disregard of the $30 monthly deduction or the 4-month disregard of one-third of their remaining monthly earned income. States have the option of extending this coverage for an additional 6 months to families who would be eligible for AFDC if the disregard were applied.

—*Families Losing AFDC Because of Child or Spousal Support.* Coverage also must be extended for 4 months to certain families who, between August 16, 1984 and September 30, 1988, lose AFDC because of receiving child or spousal support payments. This extenion applies to families who were receiving AFDC for at least 3 of the preceding 6 months.

States are also required to extend categorically needy coverage to additional groups though persons in the group are not actually receiving a cash payment. Coverage must be extended for the following groups for an unlimited period, provided the individuals in the group continue to meet the requisite criteria:

—*Persons Whose Cash Payment Would be Less Than $10.* Persons denied an AFDC cash payment solely because the payment amount would be less than $10 must be covered by Medicaid.

—*Persons Whose AFDC Payments are Reduced to Zero Because of Recovery of Overpayment of AFDC Funds.*

—*Work Supplementation Participants.* Title IV–A of the Social Security Act permits States to operate work supplementation programs in which AFDC may be used to subsidize a job for an AFDC recipient. Participants under such a work supplementation program must be covered if they are deemed by the State to be AFDC recipients and if they would otherwise qualify for AFDC except for participation in work supplementation programs. Coverage is extended to an individual's children and other individuals in the household.

—*Adoption Assistance.* Title IV–E of the Social Security Act authorizes Federal matching for State adoption assistance programs intended to lessen the barriers to adoption of children with special needs. Medicaid coverage is required for those children covered under such agreements who are former AFDC, AFDC foster care, or SSI children. A child for whom an adoption assistance agreement is in effect is eligible in the State in which he or she resides regardless of whether that is the State with which the adoptive parents have an adoption assistance agreement.

—*Foster Care.* Title IV–E of the Social Security Act authorizes Federal matching funds for State expenditures for foster care maintenance payments for care of certain children. Some children for whom foster care payments are being made must be covered under Medicaid. Mandatory coverage applies to those receiving foster care payments who would be eligible for AFDC payments except for their removal from the home and placement in foster care. These children are eligible for Medicaid in the State where they live. Effective April 1, 1988, when an individual in foster care is the minor parent of a child in the same home or institution, the individual's child is deemed to be a foster care child for purposes of Medicaid eligibility.

—*Individuals Ineligible for AFDC Because of a Requirement Prohibited Under Medicaid.* A State must extend Medicaid to persons who would be eligible for AFDC except for a requirement specifically prohibited under Medicaid. For example, AFDC permits States to impose liens against property which may make a person ineligible for cash payments. However, Medicaid prohibits States from placing liens against a recipient's property. (See Section IV.C., "Liens" in this chapter).

—*Individuals Eligible for Medicaid Except for the 1972 Social Security Increase.* Medicaid must cover individuals who would be eligible for AFDC except for the 20 percent increase in social security benefits occurring in August 1972.

3. MANDATORY COVERAGE OF PREGNANT WOMEN AND CHILDREN [8]

A State may provide cash assistance under its AFDC program to pregnant women (without other children in the home) meeting AFDC income and resources requirements; AFDC benefits may begin with the 6th month of pregnancy. Regardless of a State's decision under its AFDC program, Medicaid coverage must begin for all pregnant women meeting AFDC income and resources requirements from the medical verification of pregnancy.

A woman who was eligible for and received Medicaid while pregnant remains eligible for all pregnancy-related and post-partum services under the plan through the end of the month in which the 60 day period (beginning on the last day of pregnancy) ends.

A child born to a woman who is eligible for and receiving Medicaid on the date of the child's birth is deemed eligible for Medicaid for 1 year so long as the mother remains eligible and the child remains in the same household.

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[8] See also subsection "4" concerning optional coverage of "Ribicoff children" and section III concerning optional and mandatory coverage of additional pregnant women and children.

States are required to phase-in Medicaid coverage for all young children who would be eligible for AFDC except that they don't meet the definition of dependent child. For example, the child may be in a two-parent family where the principal breadwinner is employed. A State is required to extend Medicaid coverage to all such children under age 7 (or at State option, under age 8) born after September 30, 1983.

4. OPTIONAL COVERAGE OF ADDITIONAL PERSONS

States may elect to extend categorically needy coverage to certain additional groups of AFDC-related persons though these persons are not actually receiving a cash payment. These individuals, sometimes referred to as "optional categorically needy" may include the following:

—*Ribicoff Children.*[9] As noted above, States are required to phase- in coverage of young children up to age 7, born after September 30, 1983, who would be eligible for AFDC if they met the definition of dependent child. States also have the option of covering older children under age 21 (or at State option, under age 20, or under 19, or under 18) who would be eligible for AFDC if they met the definition of dependent child. States may cover all or reasonable categories of such persons. Reasonable categories include children in two-parent families, those who live in privately subsidized foster care, or those who live in certain institutional settings such as intermediate care facilities. Table II–3 shows State coverage decisions with respect to Ribicoff children, as of December 1986.

Table II–3.—STATE COVERAGE OF RIBICOFF CHILDREN, DECEMBER 1986

State	Covers all children under age	Covers reasonable [1] categories of children under age
Alabama	—	18
Alaska	21	—
Arizona	18	—
Arkansas	21/18	—
California	21	—
Colorado	—	21
Connecticut	21	—
Delaware	—	21
District of Columbia	21	—
Florida	18	—
Georgia	18	—
Hawaii	—	19
Idaho	—	21
Illinois	18	—
Indiana	—	18
Iowa	21	—

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[9] This group is named after former Senator Ribicoff, sponsor of legislation authorizing coverage for this group.

Table II–3.—STATE COVERAGE OF RIBICOFF CHILDREN, DECEMBER 1986—Continued

State	Covers all children under age	Covers reasonable [1] categories of children under age
Kansas	[2] 18	[2] 21
Kentucky	—	19
Louisiana	—	21
Maine	21	—
Maryland	21	—
Massachusetts	21	—
Michigan	21	—
Minnesota	21	—
Mississippi	18	—
Missouri	21	—
Montana	—	21
Nebraska	20	—
Nevada	—	19
New Hampshire	—	19/18
New Jersey	21	—
New Mexico	—	18
New York	21	—
North Carolina	18	—
North Dakota	21	—
Ohio	21	—
Oklahoma	21	—
Oregon	—	21
Pennsylvania	21	—
Rhode Island	—	19
South Carolina	18	—
South Dakota	—	21
Tennessee	21	—
Texas	19	—
Utah	18	—
Vermont	21	—
Virginia	—	21
Washington	—	21
West Virginia	—	18
Wisconsin	18	—
Wyoming	—	19
Total number of States	32	[2] 19

[1] Reasonable categories include children in two parent families, those who live in privately subsidized homes, and those who live in certain institutional settings.

[2] Kansas covers all children under age 18 and reasonable categories under age 21. It is therefore included in the total of States covering all categories of Ribicoff children below a specified age.

Source: National Governors' Association. State Medicaid Information Center. A Catalogue of State Medicaid Program Changes, 1986. 1988. p.79.

—*Individuals Who Would Be Eligible if the State's AFDC Plan Were as Broad as Allowed by Law.* For example, Medicaid may cover families with unemployed parents even though the State does not have an AFDC–UP program. (Note that States are required to cover pregnant women and children under age 7 born after September 30, 1983 in such families.) Table II–1 (which shows which States have AFDC–UP programs) also shows which States have elected to provide Medicaid, but not cash, to these families. A total of 31 States, including D.C., provide AFDC and Medicaid or just Medicaid to families where the principal breadwinner is unemployed.

- *Children Under Certain Adoption Assistance Agreements.* As noted, States are required to provide Medicaid coverage to certain children covered under title IV–E adoption assistance agreements. In addition, a State may cover children for whom state adoption assistance agreements (other than under title IV–E) are in effect if the State determines that such child has special needs. Further, the child must have been eligible for Medicaid (or would have been eligible for Medicaid under the title IV–E foster care program) prior to the time the adoption assistance agreement was entered into. Once initial eligibility has been established, it does not have to be redetermined as long as the adoption agreement is in effect.[10]
- *Individuals Eligible for AFDC But Not Receiving It.* This may include persons who have not applied.
- *Institutionalized Individuals Who Would be Eligible for Cash Assistance if They Left the Institution.*
- *Individuals Who Would be Eligible for AFDC if Child Care Costs were Paid from Earnings.* These are persons whose work-related child care costs are paid by a State agency.
- *Health Maintenance Organization (HMO) Enrollees.* Individuals who, due to fluctuations in income or resources, lose their eligibility while enrolled in certain HMOs or other prepaid health plans may be covered for an additional period specified by the State. This period may not exceed 6 months from the date of initial enrollment.

B. COVERAGE OF THE AGED, BLIND, AND DISABLED

The Federal SSI program [11] provides monthly cash payments, in accordance with uniform nationwide eligibility requirements, to needy persons who are age 65 or over, blind, or disabled.[12]

Individuals and couples are considered to be eligible if their countable income (which includes certain disregards such as the first $20 of monthly social security benefits) does not exceed the benefit standards. As of January 1, 1988, the regular Federal monthly benefit standard is $354 for an individual or $532 for a couple.[13]

Eligible individuals and couples must also have countable resources less than a specified amount. In 1988 this amount is $1,900 for an individual and $2,850 for a couple. The limit will be $2,000 for an individual and $3,000 for a couple in 1989 and thereafter.

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[10] Children under adoption assistance agreements may also be covered as a reasonable classification of "Ribicoff children." To be covered as "Ribicoff children" they are not required to have special needs for medical or rehabilitative care; however, they must meet and continue to meet the income and resources requirements of the State's AFDC plan.

[11] For further discussion of the SSI program see: U.S. Congress, House, Committee on Ways and Means. Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means. Committee Print, WMCP: 100–29. U.S. Govt. Print. Off. March 24, 1988.

[12] The SSI program replaced, effective Jan. 1, 1974, the previously existing Federal/State cash assistance programs for old-age assistance, aid to the blind and aid to the permanently disabled. However, the Federal/State programs were retained in Puerto Rico, the Virgin Islands, and Guam. Medicaid eligibility in these jurisdictions is linked to eligibility under these cash assistance programs.

[13] The SSI law provides that if an SSI applicant or recipient is "living in another person's household and receiving support and maintenance in kind from such person" the value of such in-kind assistance is presumed to equal one-third of the regular SSI benefit standard. The standard applicable to such an individual is equal to two-thirds of the regular standard.

Countable resources include liquid assets such as savings accounts, mutual fund investments, certificates of deposit, etc. Excluded from countable resources are:

—life insurance with a face value of up to $1,500;
—an automobile with a market value of $4,500 or less;
—a burial space and up to $1,500 per person for burial expenses;
—personal effects with a value of $2,000 or less, and
—a home of any value, as long as it is used as the applicant's principal place of residence.

States, at their own expense, may supplement the Federal program by paying a State supplementary payment (SSP) to some or all groups of SSI recipients.

1. MANDATORY COVERAGE FOR SSI RECIPIENTS

Thirty-five States and the District of Columbia provide Medicaid coverage to all recipients of Federal SSI payments.

Fourteen States have chosen to employ more restrictive criteria under the so-called "209(b)" option.[14] States electing this option may limit Medicaid coverage of SSI recipients by requiring such persons to meet any more restrictive eligibility criteria that were in effect on January 1, 1972 (before implementation of SSI). Table II–4 shows the 14 "209(b) States."

Table II–4.—STATES USING MORE RESTRICTIVE CRITERIA THAN SSI STANDARDS TO DETERMINE MEDICAID ELIGIBILITY ("209(b) STATES") JANUARY 1, 1988

Connecticut
Hawaii
Illinois
Indiana
Minnesota
Missouri
Nebraska
New Hampshire
North Carolina
North Dakota
Ohio
Oklahoma
Utah
Virginia

Source: Commerce Clearing House. Medicare and Medicaid Guide. Chicago. Updated periodically.

A 209b State may choose more restrictive criteria than SSI in defining blindness or disability. It may also utilize lower income and resources standards and/or utilize an alternative method of calculating these items. However, in no case can the criteria used by a 209b State be more restrictive than those in effect under the State's Medicaid plan in January 1972.

States which have elected to use the 209b option are generally more restrictive than SSI on only a few criteria. Further, some criteria might be considered more liberal than SSI. Electing the 209b option enables a State to continue to determine eligibility in a way that fits with other State programs and policies rather than be required to adopt all SSI program details.[15]

States which elect to use more restrictive criteria must allow applicants to deduct medical expenses from income (not including SSI or optional SSP payments) in determining eligibility. This is sometimes referred to as the "209(b) spend-down." For example, if an applicant has a monthly income of $400 (not including any SSI or SSP payments) and the State's income standard is $360, the applicant is required to incur $40 in medical expenses (i.e., spend- down) before he or she can be eligible for Medicaid in that month.

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[14] Section 209(b) of the Social Security Amendments of 1972 (Public Law 92–603) permitted States to restrict coverage for the aged, blind, and disabled.

[15] U.S. Library of Congress. Congressional Research Service. Medicaid Eligibility for the Elderly in Need of Long Term Care. CRS Report for Congress No. 87–986, EPW, by Edward Neuschler with the assistance of Claire Gill. CRS Report prepared under Contract No. 86–26 with National Governor's Association. Center for Policy Research. Health Policy Studies. Washington, Sept. 1987. p. 92. (Hereafter cited as Medicaid Eligibility for the Elderly in Need of Long Term Care)

Table II–5 shows the maximum potential SSI benefits (including SSP payments) for aged persons and for aged couples living independently with no other income, as of January 1988. In the majority of States, the effective Medicaid income eligibility standard is the same amount. Because specified amounts of personal income are disregarded in determining eligibility for SSI and most State supplement payments, a person with income which exceeds the maximum benefit may still be eligible for cash assistance and therefore Medicaid. In a few States, however, the effective Medicaid income eligibility standard is below the cash assistance standard. As of the second quarter of 1987, the effective eligibility standard was below the cash standard in the following five States: Hawaii, Illinois, Indiana, North Carolina, and Utah.[16] (These are all 209(b) States).

Table II–5.—MAXIMUM POTENTIAL SSI BENEFITS FOR AGED INDIVIDUALS AND FOR COUPLES LIVING INDEPENDENTLY, JANUARY 1988 [1]

State	Maximum SSI benefit	
	Individual	Couple
Alabama	$354	$532
Alaska	659	976
Arizona	354	532
Arkansas	354	532
California	575	1,066
Colorado	412	648
Connecticut	393	602
Delaware	354	532
District of Columbia	369	562
Florida	354	532
Georgia	354	532
Hawaii	359	541
Idaho	[2] 427	[2] 576
Illinois	[3] N/A	[3] N/A
Indiana	354	532
Iowa	354	532
Kansas	354	532
Kentucky	354	532
Louisiana	354	532
Maine	364	547
Maryland	354	532
Massachusetts	483	734
Michigan	384	577
Minnesota	[4] 389	[4] 598
Mississippi	354	532
Missouri	354	532
Montana	354	532

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[16] Medicaid Eligibility for the Elderly in Need of Long Term Care. p. 60.

Table II-5.—MAXIMUM POTENTIAL SSI BENEFITS FOR AGED INDIVIDUALS AND FOR COUPLES LIVING INDEPENDENTLY, JANUARY 1988 [1]—Continued

State	Maximum SSI benefit	
	Individual	Couple
Nebraska	397	598
Nevada	390	606
New Hampshire	[5] 381	[5] 553
New Jersey	385	557
New Mexico	354	532
New York	426	625
North Carolina	354	532
North Dakota	354	532
Ohio	354	532
Oklahoma	418	660
Oregon	356	532
Pennsylvania	386	581
Rhode Island	413	643
South Carolina	354	532
South Dakota	369	547
Tennessee	354	532
Texas	354	532
Utah	363	550
Vermont	[6] 412	[6] 638
Virginia	354	532
Washington	[7] 382	[7] 554
West Virginia	354	532
Wisconsin	457	698
Wyoming	374	572

[1] In most States these maximums also apply to blind or disabled SSI recipients who are living in their own households; but some States provide different benefit schedules for each category.

[2] State disregards $20 of SSI payment in determining the State supplementary payment.

[3] State decides benefits on case-by-case basis. The average payment was $57 in November of 1987.

[4] Payment level for Hennepin County. State has 10 geographic payment levels.

[5] State disregards $13 of an individual's income in determining the supplementary payment. The State supplementary payment amount is rounded to next higher dollar.

[6] State has two geographic payment levels—highest are shown in table.

[7] Sum paid in King, Pierce, Kitsap, Snohomish, and Thurston Counties.

Source: Table prepared by the Congressional Research Service (CRS) on the basis of data from the Social Security Administration (except for Connecticut and Illinois).

2. MANDATORY COVERAGE FOR ADDITIONAL PERSONS

States are also required to extend Medicaid coverage to additional groups of aged, blind, and disabled persons. A number of these mandatory extensions are included in the law in order to prevent the situation where an increase in a social security benefit could result in a loss of SSI eligibility and thus inadvertently terminate Medicaid coverage at the same time. Coverage must be extended to the following groups provided the individuals continue to meet the requisite criteria:

—*Recipients of Social Security Increases after April 1977.*[17] A State must cover former SSI recipients who receive social security benefits, but lose their SSI or SSP payments following a social security cost-of-living increase (COLA), if they would still be eligible for SSI or SSP but for the COLA increase.[18] In a 209(b) State, Medicaid must be provided to these persons when their income (after disregard of the COLA and deduction of incurred medical expenses) falls below the State standard.

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[17] This provision is sometimes referred to as the Pickle amendment.

—*Disabled Widows and Widowers Receiving Increases Under 1983 Amendments.* The Social Security Amendments of 1983 made certain changes with respect to calculation of benefits for certain disabled widows and widowers; as a result, payments were increased for some persons. A State must cover under Medicaid disabled widows and widowers whose benefits were increased and who would be eligible for SSI and/or optional SSP payments except for the revised calculation and subsequent COLA adjustments. Persons affected by this provision are required to file a Medicaid application prior to July 1, 1988.

—*Retention of Medicaid for Certain Widows and Widowers.* An individual who would otherwise qualify for SSI on the basis of disability or blindness, but beginning at age 60 qualifies for social security early widow's or widower's benefits may lose SSI. Effective July 1, 1988, such persons shall be deemed eligible for Medicaid until they qualify for Medicare.

—*Disabled Adult Children.* Effective July 1, 1987, States are required to cover persons who: (a) are at least 18 years old and received SSI benefits on the basis of blindness or disability that began before age 22; (b) become entitled to social security child's benefits or an increase in such benefits on the basis of disability; and c) cease to be eligible for their SSI benefits (and related Medicaid eligibility) because of such child's insurance benefits or increase in such benefits.

—*Individuals Receiving Mandatory State Supplements.* States are required to make mandatory State supplementary payments to any individual who would otherwise receive less under SSI than he or she received under the old Federal/State cash assistance programs.

—*Grandfathered 1973 Recipients.* Persons eligible in December 1973 (according to rules in effect in that month) as disabled, blind, essential spouse, or institutionalized must continue to be covered under Medicaid provided they have continued to meet the December 1973 criteria.

—*Individuals Eligible for Medicaid Except for the 1972 Social Security Increase.* Medicaid must cover individuals who would be eligible for SSI except for the 20 percent increase in social security benefits occurring in August 1972. Persons covered under this provision must have been entitled to social security and receiving cash assistance on that date.

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[18] HHS and the States initially limited the application of this provision to persons whose loss of SSI or SSP was caused specifically by this increase. A Ninth Circuit Court affirmed a district court decision in a class action suit which held that the "but for" test rather than the "solely" test must be used in implementing the provision. (*Raymon and JoAnn Lynch* v. *Peter Rank,* 747 F. 2d 528 (9th Circuit, 1984)). In *Raymon and JoAnn Lunch* v. *Dawson* (9th Circuit, 1987) the "but for" test was extended to cases where the social security income of the applicant's spouse is increased.

3. OPTIONAL COVERAGE OF RECIPIENTS OF STATE-ONLY SUPPLEMENTARY RECIPIENTS

States may provide optional State supplementary cash payments to one or more groups of persons not receiving SSI payments. These "SSP-only" payments must be based on need and available on a statewide basis. States may elect to provide Medicaid to one or more groups receiving optional SSP-only if they would be eligible for SSI except for income. The following are the groups which have been identified:

- —All aged;
- —All blind individuals;
- —All disabled individuals;
- —Aged individuals in domiciliary facilities or other group living arrangement as defined under SSI;
- —Blind individuals in domiciliary facilities or other group living arrangement as defined under SSI;
- —Disabled individuals in domiciliary facilities or other group living arrangement as defined under SSI;
- —Individuals receiving a federally-administered optional State supplement; or
- —Individuals in additional classifications specified by the Secretary for Federally-administered supplementary payments.

As of the second quarter of 1987, 32 States provided SSP-only payments to one or more of the above categories and also provided automatic Medicaid coverage to these groups. (See table II-6). In some instances, a SSP-only recipient, who is not automatically covered may be able to gain coverage under the State's medically needy program.

Table II–6.—STATES PROVIDING AUTOMATIC MEDICAID COVERAGE TO SSP-ONLY RECIPIENTS (AS OF THE SECOND QUARTER OF 1987)

Alabama
Alaska
California
Colorado
Connecticut
District of Columbia
Hawaii [1]
Idaho
Illinois
Indiana
Iowa
Kentucky
Maine
Maryland
Massachusetts
Michigan
Minnesota
Missouri
Nebraska
Nevada
New Hampshire
New Jersey
New York
North Carolina
Ohio
Oklahoma
Pennsylvania
Rhode Island
South Carolina
Virginia
Washington
Wisconsin

[1] Hawaii provides automatic Medicaid coverage to only some SSP-only recipients.

Sources: (1) U.S. Library of Congress. Congressional Research Service. Medicaid Eligibility for the Elderly in Need of Long-Term Care. Report 87–986 EPW, by Edward Neuschler, Center for Health Policy Studies, National Governors' Association, Sept. 1987, and (2) Commerce Clearing House. Medicare and Medicaid Guide. Chicago. Updated periodically.

4. OPTIONAL COVERAGE OF INSTITUTIONALIZED INDIVIDUALS UNDER A SPECIAL INCOME LEVEL

States may extend Medicaid eligibility to institutionalized individuals whose income, before deductions or disregards, does not exceed a special income level. This income level, established by the State, may not exceed 300 percent of the SSI benefit amount payable to an individual in his own home with no other resources. In

1987, the maximum level was $1,020; in 1988, the maximum level is $1,062. Table II–7 shows those States which offered, effective for the second quarter of 1987, coverage to institutionalized persons under the special income standard. The amount of the 1987 standard is also shown. As indicated, many of the States update their standards automatically when the SSI amount is increased in January; a number of other States increase their standards annually though the increase is not automatic.

Table II–7.—STATES USING SPECIAL INCOME STANDARD FOR INSTITUTIONALIZED AND AMOUNT OF SUCH STANDARD (AS OF THE SECOND QUARTER OF 1987)

State	Amount of Standard		Standard updated automatically
	Gross income must be less than	And/or net income must be less than	
Alabama	$852.90		
Alaska	1,020.00		X
Arkansas	1,020.00		X
Colorado	1,020.00		
Delaware	632.00		X
Florida		881.00	
Georgia		937.00	X
Idaho	1,020.00		X
Iowa	1,020.00		X
Kentucky	1,020.00		X
Louisiana	1,020.00		X
Maine	1,020.00	Nursing home rate	
Mississippi	1,020.00		
Nevada	734.00		
New Hampshire	859.00	Nursing home rate	X
New Jersey	1,020.00		
New Mexico	871.00		
Oklahoma	1,020.00		
Oregon	1,020.00		X
Pennsylvania	1,020.00		X
Rhode Island	1,020.00		X
South Carolina	1,020.00		X
South Dakota	1,020.00		
Tennessee	1,020.00	Nursing home rate	X
Texas	658.65		
Vermont	1,020.00		X
Virginia	1,020.00		X
Washington	1,020.00		X
West Virginia	1,020.00		
Wyoming	1,020.00		X

Source: U.S. Library of Congress. Congressional Research Service. Medicaid Eligibility for the Elderly in Need of Long-term Care. Report No. 87–986 EPW, by Edward Neuschler, Center for Health Policy Studies, National Governors' Association, Washington, Sept. 1987. p. 124.

States without medically needy programs use this special income level to provide coverage for their nursing home population. These States are thus able to place an absolute income ceiling on initial eligibility for Medicaid. Some States offer coverage for these persons under both the special income standard and a medically needy program. Once an institutionalized individual has attained Medicaid eligibility, either under the special income level or as a medically needy individual, he or she is expected to contribute income over specified amounts to the cost of care.

5. OPTIONAL COVERAGE OF ADDITIONAL GROUPS

States may extend optional categorically needy coverage to certain additional population groups as follows:

—*Individuals Eligible for SSI But Not Receiving It.*

—*Institutionalized Individuals Who Would Be Eligible for Cash Assistance if They Left the Institution.*

—*HMO Enrollees.* Individuals who lose their eligibility while enrolled in certain HMOs or other prepaid plans may be covered for an additional period specified by the State not exceeding 6 months from the date of initial enrollment.

—*Waiver Beneficiaries.* Individuals receiving home and community based services under a waiver,[19] who would be eligible for Medicaid if they were institutionalized, and would require institutionalization in the absence of such waivered services.

—*Hospice Beneficiaries.* States may cover hospice services under their Medicaid programs. In States covering this service, terminally ill individuals who have voluntarily elected to receive such care must be covered if they would be eligible for Medicaid if they were in a medical institution.

6. SPECIAL PROVISIONS FOR THE DISABLED

The law contains several eligibility provisions designed to address the special needs of the disabled. These are designed to assure that disabled persons are not discouraged from working nor are disabled children prevented from returning home due to the potential loss of Medicaid eligibility.

a. Mandatory continuation coverage of working blind and disabled persons. Both the SSI and Medicaid law contain similar provisions which provide incentives for severely disabled persons who work despite their impairments. These provisions provide Medicaid continuation coverage for persons previously eligible for SSI and Medicaid. Under section 1619(a) of the Social Security Act, disabled SSI recipients who lose eligibility for regular SSI benefits, because of their earnings, may receive a special SSI benefit. A person who receives a special SSI payment is also eligible for Medicaid. Under section 1619(b) of the Social Security Act, a blind or disabled individual who loses eligibility for SSI, SSP, or special SSI payments under section 1619(a) because of earnings is deemed to be eligible for SSI, for purposes of Medicaid eligibility determinations, provided certain conditions are met. Section 1619(b) further requires 209(b) States to include qualified severely impaired individuals who met the State's more restrictive criteria in the month before the month they met the requirements of Section 1619.

The Medicaid law also contains a provision requiring coverage of "qualified severely impaired" individuals. The definition of such individuals is virtually identical to that under section 1619(b). The Medicaid provision specifies that these are persons who in the month preceding application of the provision were eligible for Medicaid and received SSI, SSP, or special SSI payments under 1619(a). Further, the Secretary must determine for these persons that:

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[19] See discussion of home and community based services waivers in chapter VI.

- —They continue to be blind or continue to have a disabling physical or mental impairment;
- —Except for earnings, they continue to meet all non-disability related requirements for SSI eligibility;
- —Their unearned income is not enough to make them ineligible for SSI payments;
- —The lack of Medicaid eligibility would seriously inhibit ability to continue or obtain employment; and
- —The individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits (SSI, SSP if provided, Medicaid, and publicly funded attendant care services) that would be available in the absence of such earnings.

Any individual who, pursuant to the 1619(b) provisions, was eligible for Medicaid in June 1987 is considered qualified severely impaired so long as he continues to meet the criteria.

b. Optional coverage of noninstitutionalized disabled children. An individual is eligible for SSI if his or her income and resources are below established limits. For a child under age 21, the total income and resources of the applicant's parent are automatically considered available, i.e., "deemed" to the individual. However, the deeming provisions only apply to individuals living in the same household as their parents. An institutionalized individual is no longer considered to be living in the same household as his or her parents after the first full month of institutionalization. Subsequently, only the income actually contributed by the parents of the institutionalized person is considered.

A child may be eligible for SSI, and therefore in most States automatic Medicaid coverage, while institutionalized. However, the same child may not be eligible when living at home because of SSI deeming rules. To obtain or retain SSI and therefore Medicaid, some individuals remain in the institution though their medical needs could be taken care of at home. This situation was dramatized in 1982 by the case of Katie Beckett. Katie Beckett was a ventilator-dependent institutionalized child who was unable to go home, not because of medical reasons but because she would no longer have been eligible for Medicaid. The case received national attention and the President intervened on her behalf.

Under a provision of law sometimes referred to as the "Katie Beckett" provision, States are given the option of extending Medicaid to certain disabled children living at home. In order to qualify, the following conditions must be met:

- —the individual would be eligible for Medicaid if he/she was institutionalized;
- —the individual requires the level of care provided in a hospital, skilled nursing facility, or intermediate care facility;
- —it is appropriate to provide such care outside of the facility; and
- —the estimated cost of care at home is no more than the estimated cost of institutionalized care.

States electing this option are required to cover on a statewide basis all disabled children meeting these criteria. As of March 1988,[20] the following States offered this coverage: Arkansas, Connecticut, District of Columbia, Georgia, Hawaii, Idaho, Maine, Massachusetts, Montana, Nebraska, Nevada, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Vermont, Washington, West Virginia, and Wisconsin.

States may also offer coverage to blind and disabled persons under a "model" home and community-based services waiver. (See chapter VI.)

II. MEDICALLY NEEDY

States have the option of covering the "medically needy" under their Medicaid programs. These are persons: (1) who, except for income and resources, fall into one of the categories covered by the State (i.e., aged, blind, disabled, families with dependent children, pregnant women, and certain children); and 2) whose income and/or resources are in excess of the standards for categorically needy coverage, but below medically needy standards established by the State. A State having a medically needy program must, at a minimum, provide coverage to children and pregnant women who would be eligible as mandatory categorically needy, except for their incomes and resources. As a minimum, the State is required to offer ambulatory services to these children and prenatal and delivery services to the pregnant women. However, most States which have medically needy programs also cover additional categories of persons.

As of July 1987, 36 States (including D.C.) as well as the Northern Mariana Islands, Puerto Rico, and the Virgin Islands had medically needy programs. Two States—Georgia and Texas—offered limited programs with coverage restricted to pregnant women and children. In these two States, persons requiring coverage for nursing home care may be able to obtain coverage under the special income standard. (See subsection I.B.4 above.)

Many persons who become medically needy do so only after they have incurred medical expenses in an amount sufficient to reduce their resources and/or incomes to the medically needy levels. This is particularly true in the case of persons requiring long term nursing home care. An individual may have a sufficient income and/or resources to meet his needs while living in the community. However, when that individual becomes institutionalized, the cost of nursing home care—which averages $22,000 a year [21]—can rapidly deplete any available resources. As a practical matter, the medically needy program is primarily a benefit for institutionalized elderly and disabled persons. Essentially, it offers protection against catastrophic medical costs. However, the benefit does not become available until an individual has reduced his or her income and resources to minimum levels.

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[20] Telephone conversation with an official of the Health Care Financing Administration, Mar. 1988 based on a Mar. 16, 1988 survey by the regional offices.

[21] U.S. Dept of Health and Human Services. Report to Congress and the Secretary by the Task Force on Long-Term Health Care Policies. Sept. 21, 1987. p. 69.

States having medically needy programs establish resources and income standards. State established resource standards must be based on family size, uniform for all individuals in a group and reasonable.[22] Generally, the resource standard must either be at least equal to the highest resource standard used for the comparable categorically needy group, or the highest standard for all categorically needy groups if the State uses only one resource standard. In 209(b) States, the standard for the aged, blind, and disabled must be at least as high as that used under the State's medically needy program in January 1972. Table II–8 shows the resource standards applicable for one and two persons, as in effect for the second quarter of 1987.

Table II–8.—MEDICALLY NEEDY RESOURCE STANDARDS (AS OF THE SECOND QUARTER OF 1987)

State	Allowable Liquid Resource Levels	
	Individual	Couple
Arkansas	$1,800	$2,700
California	1,800	2,700
Connecticut	1,600	2,400
District of Columbia	2,600	2,700
Florida	5,000	5,500
Hawaii	1,800	2,700
Illinois	1,800	2,700
Iowa	1,800	2,700
Kansas	1,800	2,700
Kentucky	1,800	3,600
Louisiana	1,800	2,700
Maine	1,800	2,700
Maryland	2,500	2,700
Massachusetts	2,000	3,000
Michigan	1,800	2,700
Minnesota	3,750	6,450
Montana	1,800	2,700
Nebraska	1,600	2,400
New Hampshire	2,500	4,000
New Jersey	3,600	5,400
New York	3,000	4,650

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[22] Generally, the States use either the same methodology for evaluating resources as employed under the SSI program or, in the case of some 209(b) States, more restrictive criteria. Some States have however, used more liberal criteria. For example, SSI requires that an individual's resources must be below the standard effective 12:01 A.M. on the first day of the month in order for the individual to be eligible for cash payments in that month. If the individual meets the standard later in the month, he or she does not become eligible for cash payments until the following month. Some States, however, have permitted Medicaid coverage to begin at the point in the month when the individual has reduced his resources below the standard.

The Deficit Reduction Act of 1984 (DEFRA) prohibited Health Care Financing Administration (HCFA) from imposing any payment penalties based on a State using more liberal methods until 18 months after submission of a report on the issue to Congress. The Secretary transmitted the "DEFRA moratorium" report to the Congress on Aug. 17, 1987. The transmittal letter notes that the report: . . . recommends no major break from the current structure in the Medicaid program of following the methodologies of the cash assistance programs. However, the report recommends that the Social Security Act be amended to give the Secretary authority to provide for flexibility in applying such cash assistance provisions in the Medicaid program in determining eligibility for individuals not receiving cash assistance. That flexibility would be applied under prescribed criteria in certain cases where application of the cash provisions in Medicaid produces results which are inconsistent with the purpose and goals of the Medicaid program.

In lieu of the approach recommended by HCFA, Public Law 100-360 provides, retroactive to Oct. 1, 1982, that States have the flexibility to establish income and resource methodologies under medically needy, optional categorically needy, and under the "209(b)" option that are less restrictive, i.e. more generous, than those applied in the corresponding cash program.

Table II–8.—MEDICALLY NEEDY RESOURCE STANDARDS (AS OF THE SECOND QUARTER OF 1987)—Continued

State	Allowable Liquid Resource Levels	
	Individual	Couple
North Carolina	1,500	2,250
North Dakota	3,000	6,000
Oklahoma	1,800	2,700
Oregon	1,800	2,700
Pennsylvania	2,400	3,200
Rhode Island	4,000	6,000
Tennessee	1,800	2,700
Utah	1,800	2,700
Vermont	1,800	2,700
Virginia	1,800	2,700
Washington	1,800	2,700
West Virginia	1,800	2,700
Wisconsin	1,800	2,700

Sources: U.S. Library of Congress. Congressional Research Service. Medicaid Eligibility for the Elderly in Need of Long-term Care. Report No. 87–986 EPW, by Edward Neuschler, Center for Health Policy Studies, National Governors' Association, Washington, Sept. 1987. p. 118.

The income standard established by the State must be reasonable, based on family size, and uniform for all individuals in a covered group. Further, for purposes of Federal matching payments, the income standard cannot exceed 133⅓ percent of the maximum payment for similarly sized families, with no income or resources, under the State's AFDC program.[23] Table II–9 shows, effective July 1987, medically needy income levels by State. (This table does not reflect any income disregards that may be applicable.)

Table II–9.—MEDICALLY NEEDY MONTHLY PROTECTED INCOME LEVELS, FAMILY SIZES ONE THROUGH FOUR, JULY 1987

State	Family Size			
	One	Two	Three	Four
Arkansas	$108	$217	$275	$325
California	550	684	850	1,009
Connecticut	383	508	625	725
District of Columbia	362	381	485	592
Florida	275	275	359	417
Georgia	200	300	350	417
Hawaii	309	408	491	574
Illinois	267	333	458	517
Iowa	433	433	508	591
Kansas	341	460	465	470
Kentucky	192	225	267	325
Louisiana	100	192	258	317
Maine	358	408	541	683
Maryland	334	375	417	459
Massachusetts	455	616	733	850

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[23] The maximum medically needy level is tied to 133⅓ percent of the AFDC level for all groups, including the adult categories. Since SSI levels are generally higher than the AFDC levels, medically needy income levels are frequently below the categorically needy levels for the adult categories. (This is sometimes referred to as the negative band.) In *Hogan* v. *Schweiker* (U.S. S. CT. 1982) 457 U.S. 569, the Supreme Court held that this did not constitute an equal protection violation.

Table II–9.—MEDICALLY NEEDY MONTHLY PROTECTED INCOME LEVELS, FAMILY SIZES ONE THROUGH FOUR, JULY 1987—Continued

State	Family Size			
	One	Two	Three	Four
Michigan	370	508	537	565
Minnesota	466	582	709	828
Montana	304	383	404	426
Nebraska	375	375	450	525
New Hampshire	364	511	539	566
New Jersey	350	433	566	658
New York	417	609	617	625
North Carolina	233	300	350	383
North Dakota	345	400	435	530
Oklahoma	258	325	417	517
Oregon	367	467	549	667
Pennsylvania	375	400	425	517
Rhode Island	492	533	658	750
Tennessee	150	167	217	267
Texas	100	211	267	301
Utah	289	401	501	585
Vermont	412	617	617	676
Virginia	250	308	358	400
Washington	368	532	567	667
West Virginia	200	275	290	312
Wisconsin	443	592	689	823

Source: National Governors' Association. State Medicaid Information Center. A Catalogue of State Medicaid Program Changes: 1986. 1988. p. 77.

An individual with an income above the applicable medically needy level may reduce his income to the requisite level through spending on medical care. The process by which an individual reduces his income to the standard is known as the "spend-down." For example, if an applicant has a monthly income of $450 (not including any SSI or SSP payments) and the State's income standard is $400, the applicant would be required to incur $50 in medical expenses (i.e., spend-down) before he would be eligible for Medicaid. When Medicaid eligibility is triggered, the program will not pay for any of these spenddown expenses.

Medical expenses which are considered as spenddown expenses include Medicare cost-sharing charges (for persons eligible for both programs), and expenses for necessary medical and remedial services which are either included under the State's Medicaid program or recognized under State law but not included in the program. The State Medicaid agency may set reasonable limits on amounts deducted.

States use a time period from 1 to 6 months in calculating the spend-down. Generally a shorter period is more beneficial to the applicant. Using the above example, if the State has a 1 month spend-down calculation period, the individual would be required to incur $50 of medical expenditures in a month, after which covered services would be paid by Medicaid. The same calculation and spend-down requirements would be made the following month. On the other hand, if the State has a 6 month calculation period, the individual would have to incur $300 ($50 x 6) in medical expenses before Medicaid would begin coverage; coverage would continue for the remainder of the 6-month period. The length of the calculation period would not significantly affect total out-of-pocket expenditures for persons with recurring and predictable medical expenditures because they would be required to spend-down $50 each month. However, individuals faced with acute non-recurring problems generally benefit more from a shorter calculation period. As of the second quarter of 1987, 18 States used a 6-month period, 7 a 3-month period, 10 a 1-month period, and 1 State a combination of time periods.[24]

III. TARGET GROUPS

Beginning with OBRA86, legislation was enacted which permitted States, without raising their cash assistance standards, to extend categorically needy coverage to certain target groups with incomes below the Federal poverty line. OBRA87 expanded those options. With the enactment of Public Law 100–360, coverage of certain of these groups is mandated on a phased-in basis.

The Omnibus Budget Reconciliation Act of 1986 (OBRA86), permitted States to extend categorically needy Medicaid coverage to specified groups of individuals with incomes below the Federal poverty line who were not previously eligible for such coverage.[25] The first target group is composed of pregnant women, infants and young children. These are persons who are not eligible for AFDC nor included under the mandatory coverage provisions because their incomes and/or resources exceed AFDC standards. The second target group is composed of the aged and disabled. Similarly, these persons are not eligible for categorically needy coverage because their incomes and/or resources exceed the levels for the SSI population.

The Omnibus Budget Reconciliation Act of 1987 (OBRA87), further expanded States' options with respect to coverage of low-income pregnant women and infants.

The Medicare Catastrophic Coverage Act mandates States to phase-in, beginning July 1989, Medicaid coverage for pregnant women and infants below the poverty line. It also mandates States to phase-in, beginning January 1, 1989, payment of Medicare cost-sharing charges on behalf of the elderly and disabled below the povery line.

Persons who may be extended coverage under the mandatory and optional provisions include only those whose incomes fall below the requisite standards. There is no spenddown provision for these groups.

The following sections outline both the options currently available to the States and the requirements of the new mandates.

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[24] Medicaid Eligibility for the Elderly in Need of Long Term Care, p. 113.

[25] The Federal poverty guidelines are administered by the Department of Health and Human Services (DHHS) to determine eligibility for some Federal programs. The procedure for computing the guideline was developed by the Community Service Administration, approved by the Office of Management and Budget (OMB), and since Public Law 97–35, has been administered by DHHS. The guideline is based on the Census bureau definition of poverty. In 1988, the annual Federal poverty guideline for a family of three is $9,690.

A. PREGNANT WOMEN, INFANTS AND YOUNG CHILDREN

1. CURRENT OPTIONS

States currently have the option of providing Medicaid coverage to pregnant women, infants up to age 1, and children up to age 8 (born after on or after October 1, 1983) with incomes below a State-established level not exceeding 100 percent of the Federal poverty line.

Under OBRA86, the provision was effective April 1, 1987 for pregnant women and infants. Beginning in fiscal year 1988, States could increase the age level by 1 in each fiscal year until all children under age 5 were included. States could not elect to cover one age group until all younger age groups were covered.

Table II–10.—OBRA (1986) SUMMARY STATUS: COVERAGE OPTIONS SELECTED BY STATES FOR PREGNANT WOMEN AND CHILDREN AS OF JANUARY 1988

State	Adopted percent poverty	Coverage to age— 1	Coverage to age— 2	Dropped assets test	Effective date
Arizona	100		X	X	1/88
Arkansas	[1] 75/100		X		4/87
Connecticut	100	X			[2] 4/88
Delaware	100	X		X	1/88
District of Columbia	100		X	X	4/87
Florida	100		X	X	10/87
Kentucky	100		X		10/87
Maryland	100	X		X	7/87
Massachusetts	100		X	X	7/87
Michigan	100		X	X	1/88
Mississippi	100		X		10/87
Missouri	100		X		1/88
New Jersey	100		X	X	7/87
New Mexico	100		X		1/88
North Carolina	100		X	X	10/87
Ohio	100	X			1/89
Oklahoma	100		X	X	1/88
Oregon	[1] 85/100		X	X	11/87
Pennsylvania	100		X	X	[2] 4/88
Rhode Island	100		X	X	4/87
South Carolina	100	X		X	10/87
Tennessee	100		X		7/87
Utah	100		X	X	[2] 4/88
Vermont	100		X		10/87
Washington	90		X		7/87
West Virginia	100		X	X	7/87
Total	26	5	21	16	

[1] These States will increase their income thresholds to 100 per cent of poverty during 1988.

[2] Projected implementation date.

Source: National Governors' Association. State Medicaid Information Center. 1988.

OBRA87 permitted States to accelerate coverage of children under age 5 whose income is below the poverty line. Effective July 1, 1988, States can cover children under age 2, 3, 4, or 5 (as selected by the State) who are born after September 30, 1983. Effective October 1, 1988, States can expand coverage to children under age 8 born after September 30, 1983.

Imposition of resource standards for the new coverage category is optional with the States. (Table II–10 shows that the majority of States have elected to drop the assets test.) If one is established, it may not be more restrictive in the case of pregnant women than that used under SSI. For infants and children, States are not able to apply a resource standard that is more restrictive than the AFDC standard. Newly eligible pregnant women are only eligible for services related to pregnancy. For infants and children, coverage is identical to that offered other categorically needy recipients.

States which chose to cover this new population group prior to December 22, 1987 are prohibited from lowering their AFDC standard as in effect on April 17, 1986. States making elections subsequent to that date are prohibited from lowering their AFDC payment standard as in effect on July 1, 1987. The prohibition is included to prevent States from financing their Medicaid expansions by lowering their cash assistance standards.

OBRA87 also permitted States, effective July 1, 1988 to increase the State-established income level for pregnant women and infants to 185 percent of the Federal poverty guideline. States could impose a premium for such coverage. The amount of the premium could not exceed 10 percent of the amount by which the family's income (less child care expenses) exceeded 150 percent of the Federal poverty guideline for a family of comparable size. As of August 1988, Kentucky had extended coverage to 125% of poverty, while Iowa and West Virginia extended coverage to 150%. The following States extended coverage to 185% of poverty: Connecticut, Maine, Massachusetts, Michigan, Minnesota,Mississippi, and Vermont.[26]

2. MANDATED PHASE-IN

Public Law 100–360 requires States to phase-in coverage for all pregnant women and infants under age one with incomes at or below the Federal poverty line. Effective July 1, 1989, States are required to extend coverage to all such persons with incomes at or below 75 percent of poverty. Effective July 1, 1990 coverage must be extended to all such persons with incomes at or below 100 percent of poverty.[27] Coverage for pregnant women is limited to services related to pregnancy (including prenatal, delivery, postpartum and family planning services) and to other conditions which may complicate the pregnancy. Coverage for infants includes coverage for all Medicaid services offered to cash assistance recipients.

Certain maintenance of effort requirements are included, during the first year of the phase-in, for States which had already elected to provide coverage to pregnant women and infants with incomes between 75 percent and 100 percent of poverty. If on enactment of Public Law 100–360, a State offered this coverage it would be required to continue it. The maintenance of effort requirement would also apply in the the case of a State which, as of enactment, had enacted legislation authorizing or appropriating funds to provide such coverage but had not actually implemented it yet. In no case would States be required to offer coverage to pregnant women and children with incomes above poverty, though they would still have the option of extending coverage to such persons with incomes up to 185 percent of poverty. States are precluded from reducing their AFDC cash payment levels below those in effect May 1, 1988. If a State covers pregnant women and infants between 100 percent and 185 percent of poverty, it also continues to be subject to the requirement that AFDC cash payment levels cannot be reduced below those in effect on July 1, 1987.

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[26] Telephone conversation with staff of National Governors' Association, August 1988. Information was not available on whether any of the States were imposing a premium for the coverage.

[27] This mandate applies in Arizona which is operating an alternative demonstration program. The mandate does not apply in the territories.

B. Aged and Disabled

1. CURRENT OPTIONS

OBRA86 created an optional categorically needy coverage group composed of the aged and disabled with family incomes up to a State-established level that does not exceed 100 percent of the Federal poverty line. The provision was effective July 1, 1987. A State electing this option must also cover some newly eligible pregnant women and infants.

A State choosing this option is required to offer the benefit package available to other categorically needy beneficiaries. As an alternative, States can cover just the Medicare cost-sharing charges for this population group. (This is sometimes referred to as buy-in coverage).[28] The cost-sharing charges are: Part A premiums, deductibles and coinsurance, and Part B premiums, deductibles, and coinsurance. In either case, a State is required to use the SSI resource standards, except that if it has a medically needy program with higher standards, it can use those higher standards for the new group.

As of March 1988, the District of Columbia, Florida, and New Jersey had elected to provide full Medicaid coverage for aged and disabled persons under the OBRA86 provision. The District of Columbia and New Jersey provided coverage for persons below 100 percent of poverty while Florida provided coverage for persons below 90 percent of poverty.[29]

2. MANDATED PHASE-IN OF MEDICARE BUY-IN

Public Law 100–360 makes a number of significant changes to the Medicare program for the aged and disabled. It expands the coverage of services, places a maximum on beneficiary out-of-pocket expenses in connection with their use of physicians' and related services (the so-called catastrophic cap), and establishes a new catastrophic prescription drug benefit. Medicare will now pick up some expenses previously paid for under Medicaid for persons eligible for both programs.

Public Law 100–360 requires States to phase-in buy-in coverage for Medicare beneficiaries with incomes below the poverty line.[30]

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[28] See Chapter IV for a discussion of the buy-in.

[29] Telephone conversation with National Governors' Association. Mar. 1988.

[30] This mandate applies in Arizona which is operating an alternative demonstration program. The mandate does not apply in the territories.

Specifically States are required to pay Medicare premiums (including the Part A premium where applicable), deductibles, and coinsurance for elderly and disabled enrollees whose incomes are at or below poverty and whose resources are at or below twice the resources standard used under the SSI program.

Coverage is to be phased-in as follows:

—January 1989—persons with incomes at or below 85 percent of poverty;

—January 1, 1990—persons with incomes at or below 90 percent of poverty;

—January 1, 1991—persons with incomes at or below 95 percent of poverty; and

—January 1, 1992—all persons with incomes at or below 100 percent of poverty.

In the case of a 209(b) State, which as of January 1, 1987, used an income standard for the aged that was more restrictive than the SSI standard, the threshold would be set at 80 percent of poverty on January 1, 1989. The threshhold would be increased five percentage points each year until January 1, 1993, when all persons at or below 100 percent of poverty are covered.[31]

Public Law 100–360 provided, beginning January 1, 1991, Medicare coverage for outpatient prescription drugs, subject to a $600 deductible and 50 percent coinsurance charges.[32] The deductible is slated to go to $652 in 1992 and be indexed in subsequent years so that the same percentage of Medicare beneficiaries would exceed the deductible in each year. The coinsurance is slated to be lowered to 20 percent by 1993. The law requires Medicaid programs, on a phased-in basis to pay the additional premiums, deductibles and coinsurance amounts for Medicare beneficiaries with income below poverty. The phase-in schedule is the same as that applicable for other benefits. Thus as of January 1, 1991, most States will be required to buy-in for the elderly and disabled with incomes at or below 95 percent of poverty. In the case of 209(b) States, the 90 percent threshold will apply in that year.

The law provides that a State which offers a Medicaid prescription drug benefit can meet the prescription drug deductible in one of two ways. It can either cover incurred drug charges below the deductible amount or provide the same drug benefits as it offers to its categorically needy population.

The current option to offer buy-in coverage for all elderly and disabled below poverty would be retained during the phase-in period.

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[31] The following five States are expected to qualify for the extended phase-in: Hawaii, Illinois, North Carolina, Ohio, and Utah.

[32] A limited outpatient prescription drug benefit is effective Jan. 1, 1990. In this year, Medicare will cover, subject to a $550 deductible, home intravenous (IV) therapy drugs and immunosuppressive drugs after the first year following a transplantation (such immunosuppressive drugs are already covered in the first year). Twenty-percent coinsurance will apply to IV drugs and 50 percent to immunosuppressive drugs. The phased-in mandated Medicaid benefit would apply to these two categories of drugs in 1990.

IV. ADDITIONAL REQUIREMENTS AFFECTING ELIGIBILITY DETERMINATIONS

A. Treatment of Income and Resources When One Member of a Couple Is Institutionalized

Under Medicaid, the income and resources of an applicant's spouse are considered available (within certain limits) to the applicant and are therefore taken into account in determining eligibility. Similarly, the income and resources of parents are considered available, within certain limits, with respect to their children who are under age 21 or blind or disabled.[33] The income and resources of other relatives (such as adult children) are not taken into account unless actually contributed.

Special rules apply when determinations are made in behalf of institutionalized persons. These are important when one member of a couple goes into a nursing home. There has been concern that the amount of income and resources that the community-based spouse has been allowed to retain for his or her own needs has been inadequate. Public Law 100–360 incorporates major changes in Medicaid's treatment of income and resources of a couple when one member of a couple is institutionalized. These changes, which are effective September 30,1989, are intended to protect against so-called spousal impoverishment.

1. CURRENT REQUIREMENTS

a. Eligibility determinations. As noted, eligibility of the aged for Medicaid is linked to actual or potential receipt of cash assistance under SSI. The SSI program employs certain criteria for the treatment of income and resources. These criteria are also used for Medicaid in States which cover all SSI recipients; 209(b) States may employ more restrictive criteria provided the criteria are no more restrictive than those that were in effect in January 1972.

Under SSI rules, if both spouses live together, their incomes and resources are considered available to each other whether or not actually contributed to each other. Spouses are no longer considered to be living together if one is institutionalized in a Medicaid institution (hospital, skilled nursing facility, or intermediate care facility) longer than 1 month. In this case, each person is treated as an individual rather than as a couple for purposes of determining eligibility for SSI and therefore Medicaid. Only the income of the institutionalized spouse is considered for purposes of determining eligibility. While mutual consideration of income ceases in the month after institutionalization begins, resources must be considered mutually available for an additional 6 months if both spouses are SSI eligible. Resources above these specified amounts must be applied to the costs of care before the institutionalized person can become eligible for SSI and therefore Medicaid.

The "name on the instrument" rule applies in attributing income, i.e., income is considered to belong to the spouse whose name is on the instrument conveying the funds.[34] For example, if a pension check is made out to the husband, the income is considered to be his. If the husband in this case enters a nursing home, all of the income is considered to be his for purposes of determining eligibility. On the other hand, if the wife in this case enters the nursing home, none of the income is considered to be hers; Federal law does not require contribution of the husband's income to the cost of her care. In the case of social security checks, the amount attributable to each spouse is the individual's share of the couple's benefit.

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[33] See subsection I.B.6 above for discussion of coverage of disabled children.

The rules for attributing resources are comparable to those for attributing income. If liquid resources are held solely by the institutionalized spouse, they are attributed to him or her for eligibility purposes. If such resources are held jointly by the institutionalized spouse and non-institutionalized spouse, they are considered to be fully available to the institutionalized spouse.[35] If such resources are held solely by the community spouse, none is considered available to the institutionalized spouse.

b. Post-eligibility treatment of income and resources. When one spouse is institutionalized, individuals are essentially treated separately for purposes of establishing eligibility; however, they are treated as a couple for purposes of determining the required contribution to the costs of care. Payment by Medicaid to an institution for medical care in behalf of an institutionalized Medicaid beneficiary is reduced by certain amounts. The patient's income, after specified amounts known as "disregards" are subtracted, is applied to the cost of care. The disregards which are applied to the patient's income are applied in the following order:

—A monthly *personal needs allowance* which is a reasonable amount for clothing and other personal items. The minimum was increased from $25 to $30, effective July 1, 1988. Many States have used an amount slightly higher than the statutory minimum. See table II–11 for a listing of the personal needs allowances applicable in States in the second quarter of 1987.[36] The Table also includes a State-by-State listing of amounts paid for personal needs to an institutionalized resident with no other income.

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[34] Federal policy has required States to use SSI rules for determining ownership of income and resources. Thus State community property rules have not been used for Medicaid purposes except in California and Washington which have challenged the Federal policy. In 1987, the Ninth Circuit Court of Appeals held that Washington could use community property rules to determine income *(Washington Department of Social and Health Services* v. *Bowen* (CA–9, 1987) 815 F. 2d 549).

[35] Jointly held bank accounts generally allow either party to withdraw any amount on their own signature; consent of all coowners is not required. SSI considers the amount in such an account to be fully available to the applicant. If the non-applicant co-owner withdraws any or all of the funds, SSI does not consider this to be a potentially disqualifying transfer of assets (discussed in subsection B) unless the applicant participates or consents to it.

For other jointly held resources (real property, stocks and bonds, and bank accounts requiring all signatures to withdraw), the applicant generally cannot liquidate the resource without the nonapplicant's consent. Under SSI policy, the resource is not considered available if the coowner does not agree to the liquidation. A National Governors' Association survey of the States indicated that most of them presumed ownership of these resources was split 50–50, subject to rebuttal by the applicant. (Summary of treatment of resources taken from: Medicaid Eligibility for the Elderly in Need of Long Term Care, p. 42–44.)

[36] In addition, for a single individual, the agency may deduct an amount (in addition to the needs allowance) for maintenance of the individual's home if: (a) the amount is deducted for not more than a 6-month period; and (b) a physician has certified that the individual is likely to return home within that period.

Table II–11.—AMOUNTS PROTECTED FOR PERSONAL NEEDS OF A NURSING HOME RESIDENT ON MEDICAID (AS OF THE SECOND QUARTER OF 1987)

State	Monthly personal needs allowance	
	Protected out of resident's own income	Paid if resident has no income
Alabama	$25.00	$25.00
Alaska	70.00	70.00
Arkansas	25.00	25.00
California	35.00	35.00
Colorado	29.00	29.00
Connecticut	35.00	25.00
Delaware	31.00	25.00
District of Columbia	40.00	40.00
Florida	30.00	30.00
Georgia	25.00	25.00
Hawaii	25.00	25.00
Idaho	25.00	25.00
Illinois	25.00	25.00
Indiana	28.50	25.00
Iowa	25.00	25.00
Kansas	25.00	25.00
Kentucky	40.00	25.00
Louisiana	33.00	33.00
Maine	35.00	35.00
Maryland	40.00	25.00
Massachusetts	65.00	65.00
Michigan	28.00	25.00
Minnesota	40.00	40.00
Mississippi	44.00	25.00
Missouri	25.00	25.00
Montana	40.00	25.00
Nebraska	30.00	30.00
Nevada	35.00	25.00
New Hampshire	35.00	35.00
New Jersey	35.00	35.00
New Mexico	30.00	25.00
New York	40.00	40.00
North Carolina	25.00	25.00
North Dakota	45.00	25.00
Ohio	25.00	25.00
Oklahoma	25.00	25.00
Oregon	25.00	25.00
Pennsylvania	25.00	25.00
Rhode Island	30.00	25.00
South Carolina	25.00	25.00
South Dakota	25.00	25.00
Tennessee	25.00	25.00
Texas	25.00	25.00
Utah	27.00	25.00
Vermont	40.00	40.00
Virginia	30.00	25.00
Washington	36.62	36.62
West Virginia	25.00	25.00
Wisconsin	40.00	25.00
Wyoming	30.00	25.00

Sources: U.S. Library of Congress. Congressional Research Service. Medicaid Eligibility for the Elderly in Need of Long-term Care. Report No. 87–986 EPW, by Edward Neuschler, Center for Health Policy Studies, National Governors' Association. Washington, Sept. 1987. p. 22.

—A *monthly maintenance needs allowance* for individuals with only a spouse at home. This amount, which is to be based on a reasonable assessment of the needs of the spouse, may not exceed the higher of:

- The SSI standard (currently $354) for an individual residing in his own home if the State covers only SSI recipients;
- The highest income standard (in the appropriate category of age, blindness, or disability) for optional State supplementary payments; or
- The medically needy income standard for one person.
- In "209(b)" States, the maintenance needs allowance, cannot exceed the higher of the more restrictive income standard or the medically needy income standard for one person.

—Table II–12 shows the monthly amounts (as in effect for the second quarter of 1987) that nursing home residents were allowed to protect for the maintenance needs of an outside spouse.

Table II–12.—AMOUNTS NURSING HOME RESIDENTS ON MEDICAID ARE ALLOWED TO PROTECT FOR THE MAINTENANCE NEEDS OF AN OUTSIDE SPOUSE (IN EFFECT THE SECOND QUARTER OF 1987)

State	Program standard used	Dollar amount
Alabama	Supplemental security income	$340.00
Alaska	State supplementary payment	632.00
Arkansas	Other	187.80
California [1]	Medically needy level	550.00
Colorado	Other	229.00
Connecticut [2] [3]	Medically needy level	458.33
Delaware	Supplemental security income	340.00
District of Columbia	Medically needy level	362.00
Florida	Supplemental security income	340.00
Georgia	Supplemental security income	340.00
Hawaii	Medically needy level	300.00
Idaho	State supplementary payment	413.00
Illinois [3]	State supplementary payment	varies
Indiana	Supplemental security income	340.00
Iowa	Supplemental security income	340.00
Kansas	Medically needy level	341.00
Kentucky	Medically needy level	192.00
Louisiana	Other	186.80
Maine	Supplemental security income	340.00
Maryland [3]	Medically needy level	334.00
Massachusetts	Medically needy level	455.00
Michigan [2] [3]	Medically needy level	370.00
Minnesota [3]	Medically needy level	402.00
Mississippi	Supplemental security income	340.00
Missouri	Supplemental security income	340.00
Montana	Supplemental security income	340.00
Nebraska	Medically needy level	375.00
Nevada	Aid to Families with Dependent Children	173.00
New Hampshire	State supplementary payment	354.00
New Jersey	State supplementary payment	371.25
New Mexico	Supplemental security income	340.00
New York [3]	Medically needy level	417.00
North Carolina	Medically needy level	233.00
North Dakota	Medically needy level	345.00
Ohio	Other	258.00

Table II–12.—AMOUNTS NURSING HOME RESIDENTS ON MEDICAID ARE ALLOWED TO PROTECT FOR THE MAINTENANCE NEEDS OF AN OUTSIDE SPOUSE (IN EFFECT THE SECOND QUARTER OF 1987)—Continued

State	Program standard used	Dollar amount
Oklahoma	None	$0.00
Oregon	State supplementary payment	341.70
Pennsylvania	State supplementary payment	372.40
Rhode Island	Medically needy level	491.67
South Carolina	Supplemental security income	340.00
South Dakota	Aid to Families with Dependent Children	257.00
Tennessee	Medically needy level	150.00
Texas	Supplemental security income	340.00
Utah	Medically needy level	289.00
Vermont [2]	Medically needy level	412.00
Virginia [2]	Medically needy level	325.00
Washington [1]	Medically needy level	368.00
West Virginia [3]	Medically needy level	200.00
Wisconsin	State supplementary payment	442.72
Wyoming	Aid to Families with Dependent Children	195.00

[1] Uses community property laws to allocate income among spouses.
[2] Varies by geographic area, highest level shown.
[3] Will allow additional amounts to be protected if ordered by a court.

Source: U.S. Library of Congress. Congressional Research Service. Medicaid Eligibility for the Elderly in Need of Long-Term Care. CRS Report for Congress No. 87–986 EPW, by Edward Neuschler, Center for Health Policy Studies, National Governors Association. Washington, Sept. 1987. p. 48–49.

—For an individual with a family at home, an additional amount of income is disregarded for the *maintenance needs of the family. The amount may not exceed the AFDC or medically needy income standard for a family of the same size.*

—*Amounts for medical expenses* not subject to payments by a third party. These expenses are defined by law as including: (a) Medicare and other health insurance premiums, deductibles or coinsurance charges; and (b) necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits established by the State.[37]

c. Contributions by non-institutionalized spouse to cost of care.[38] States which cover all SSI recipients are precluded from requiring contributions from the community spouse toward the cost of care for the institutionalized spouse. States using more restrictive criteria (i.e., 209(b) States) may require or request such a contribution. As of the second quarter of 1987, three States reduced payments to the nursing home by the amount the spouse was expected to contribute (whether or not the contribution was actually made). Ten of the 11 other 209(b) States told the spouse that a contribution, calculated according to a State-determined formula, was expected. Nine

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[37] This definition of expenses was originally included in regulations. On Feb. 8, 1988, the Department issued final regulations, effective Apr. 8, 1988, which would have given States more flexibility in determining what medical expenses could be disregarded. Under the new regulations, States would have had the option, rather than being required, to deduct expenses for services which were in excess of the plan's limitations on amount, duration and scope or recognized under State law but not covered under Medicaid.

Public Law 100–360 rstored, effective Apr. 8, 1988 previous policy.

[38] The information in this subsection is taken from: Medicaid Eligibility for the Elderly in Need of Long Term Care, p. 45.

States did not reduce the payment to the nursing home unless the contribution was actually made; the remaining State reduced the payment if the spouse signed a written agreement to contribute. While most States could go to court to enforce the contribution requirement, court action is rarely taken.

2. NEW REQUIREMENTS (EFFECTIVE SEPTEMBER 30, 1989)

Public Law 100–360 makes major changes in Medicaid's treatment of income and resources of a couple when one member of a couple is institutionalized. These changes apply to payments made beginning October 1, 1988. They apply to individuals who begin a continuous period of institutionalization on or after September 30, 1989, except that provisions relating to treatment of income, protection of income for the community spouse, and related fair hearing provisions apply as of September 30, 1989 to individuals institutionalized on or after that date. The new requirements are as follows:

—*TREATMENT OF RESOURCES.* A one-time determination of countable resources is to be made at the time of application for benefits; the determination is to be based on all countable resources held by either spouse on the day the institutionalized spouse begins the continuous period of institutionalization. The couple's home, household goods and personal effects are to be excluded from the calculation. (The State is required, upon the request of either spouse and receipt of relevant documentation, to provide an assesment of total joint resources. The State may charge a reasonable fee for an assessment if it is not part of an application for Medicaid).

One-half of the value of total resources is to be attributed to each spouse. If the spousal share is less than $12,000, the institutionalized spouse would be allowed to transfer a sufficient amount to enable the community spouse to hold $12,000 in his or her own name. The State could raise the $12,000 minimum resource allowance for the community spouse to any level up to $60,000. The community spouse's share cannot exceed $60,000 except where a higher amount is provided under a fair hearing or court order. Any amounts in excess of $60,000 would be attributed to the institutionalized spouse. Beginning in 1990, the $12,000 and $60,000 amounts are increased by the percentage increase in the consumer price index.

After an institutionalized spouse has established eligibility, no resources of the community spouse are to be considered available to the institutionalized spouse.

—*TREATMENT OF INCOME.* During any month after the institutionalized spouse is determined eligible for Medicaid, no income of the community spouse is considered available to the institutionalized spouse. Regardless of State laws relating to community property or division of marital property, the following attribution rules apply to non-trust property, unless otherwise specifically provided. Income paid solely to one spouse or the other is considered to belong to that respective spouse. If the income is paid in both names, half is considered available to each spouse. If the income is paid in the name of either or both spouses and another person, the income is considered available to each spouse in proportion to the spouse's interest (or if payment is made with respect to both spouses and no interest is specified, one-half of the joint interest is considered available to each spouse). The same principles apply in the case of income from trust property, unless the trust specifically provides otherwise.

An institutionalized spouse could rebut the non-trust property attibution rules by showing that ownership interests are otherwise.

—*PROTECTION OF INCOME FOR COMMUNITY SPOUSE.* As previously noted, payment by Medicaid to an institution for medical care in behalf of an institutionalized Medicaid beneficiary is reduced by certain amounts. The patient's income, after specified amounts known as "disregards" is applied to the cost of care. In response to concerns regarding spousal impoverishment, the law raises the amount of the institutionalized spouse's income that the community spouse can retain. The total amount of both spouses' combined income that may be protected for the community spouse (known as the monthly maintenance needs allowance) is $1,500; a higher amount may be determined necessary by a fair hearing or court order.

The law specifies that the following disregards are to be applied to the patient's income in the following order:

—A monthly *personal needs allowance,* which at a minimum is $30 ($60 for a couple when both are institutionalized);

—A *community spouse monthly income allowance.* This allowance is the amount needed to bring the community spouse's income up to a minimum level (i.e. the minimum monthly maintenance needs allowance). Each State is required to establish a *minimum monthly maintenance needs allowance* (not to exceed $1,500). The community spouse monthly income allowance is determined by subtacting the amount of income otherwise available to the community spouse from the minimum monthly maintenance needs allowance. The minimum monthly maintenance needs allowance equals or exceeds the sum of:

—(1) 122 percent (effective September 30, 1989) of the Federal poverty guidelines for a family of two; this is raised to 133 percent on July 1, 1991 and 150 percent on July 1, 1992; and

—(2) an excess shelter allowance (the amount by which mortgage expenses or rent, plus utility costs, exceed 30 percent of item #1).

—A *family allowance* for each family member (minor or dependent child, dependent parent or dependent sibling residing with the community spouse). The allowance is equal to at least 1/3 of the amount by which the amount calculated under item #1 (for the community spouse) exceeds the income of that family member.

—*Amounts incurred for medical expenses for medical or remedial care* not subject to payment by a legally liable third-party.

—*NOTICE/FAIR HEARING.* States are required to notify both spouses at the time of eligibility determinations, and to notify either spouse upon request, of:

—the community spouse monthly income allowance,

—the amount of any family allowance,
—the method for computing the amount of the community spouse resources allowance, and
—the spouse's right to a fair hearing with respect to ownership or availablity of income or resources and the determination of the community spouse monthly income or resources allowance.

Either spouse may request a fair hearing. Any hearing respecting the determination of the community spouse resource allowance must be held within thirty days of the request.

If either spouse establishes in a fair hearing that due to exceptional circumstances resulting in significant financial duress, the community spouse needs income above the minimum monthly maintenance needs allowance, the State is required to increase the allowance, notwithstanding the $1,500 ceiling.

The State is required to increase the community spouse resource allowance if either spouse establishes in a fair hearing that such allowance (in relation to the income generated by the allowance) is inadequate to raise the level of the income of the community spouse to the level of the minimum monthly maintenance needs allowance (taking into account any other income attributed to the community spouse).

B. Transfer of Assets

Medicaid law has contained certain provisions to allow States to deny coverage to aged, blind, or disabled persons who dispose of their resources for less than fair market value in order to gain Medicaid coverage. These provisions were intended to prevent individuals (primarily those facing long- term institutionalization) from transferring substantial assets to their families in order to bring their resources below the Medicaid eligibility level. In general, these resources must be applied to the cost of their medical care. Most States have employed so-called "transfer of assets" restrictions.

Public Law 100–360 established a new national transfer of assets policy. The new requirements are effective with respect to eligibility applications occurring on or after July 1, 1988 and apply to resources disposed of on or after such date. A State, which prior to July 1, 1988, had elected to employ tranfer of assets restrictions, could continue to apply its pre-July policies with respect to resources transfered prior to that date, even where application for Medicaid benefits is made on or after that date.

The new provisions only apply with respect to an institutionalized individual, i.e. one who is an inpatient of a medical institution or nursing facility. States are required to determine at the time of application for benefits whether an institutionalized individual has disposed, within the preceding 30 months, of resources for less than fair market value. If such a transfer has occurred, a period of ineligibility is established beginning with the month the resources were transferred. The number of months in such period equals the total uncompensated value at the time of the transfer divided by the average cost to a private patient of nursing facility services in the State or the community.

The transfer prohibition does not apply if:

- —the transfer was that of the applicant's home to: his or her spouse, child under 21, blind or disabled adult child, or sibling who has an equity interest in the home and who was residing in the home for at least a year prior to the individual's admission to the institution.
- —resources were transferred to the community spouse or to the individual's child who is blind or permanently and totally disabled.
- —a satisfactory showing is made either that the individual intended to dispose of resources at fair market value or for other valuable consideration or that resources were transferred for a purpose other than to qualify for Medicaid.
- —the State determines that the denial of eligibility would work an undue hardship.

States can only apply tranfer of assets restrictions in accordance with these provisions, i.e. they cannot impose more restrictive or less restrictive criteria.

Public Law 100–360 also repealed the prior SSI law's transfer of assets provisions. The Secretary is required, however, to inform SSI applicants of the new Medicaid provisions at the time they apply (or eligibility is redetermined) for SSI benefits. At the same time, the Secretary is also required to request from the individual information on transfer of assets and to make such information available to the Medicaid agency.

C. LIENS

A lien is a legal right to hold property or have it sold or applied for payment of a claim. States are barred, except under certain circumstances, from placing a lien on the property of a Medicaid beneficiary prior to his death because of Medicaid claims correctly paid on his behalf. However, States may place a lien at any time on both real and personal property following a court judgment that claims were incorrectly paid.

A State may place a lien on real property of institutionalized Medicaid beneficiaries who the State determines after notice and opportunity for hearing, are reasonably likely to remain in a nursing home for the remainder of their lives. States may not place a lien on the home of a beneficiary if the spouse or child under 21 or blind or disabled child is residing in the home. Further, the State may not place such a lien if the beneficiary has a sibling in the home who has an equity interest in such home and was residing there continuously for at least 1 year prior to the beneficiary's admission to the facility. Any lien dissolves if the individual is discharged from the medical institution and returns home.

A State may not make an adjustment or recover funds in satisfaction of a claim against a recipient's property except: (a) from the estate of a beneficiary who was 65 or older at the time the service was rendered; or (b) from the estate or upon the sale of the property subject to a lien when the individual is institutionalized. A foreclosure action may not be taken until after the death of the surviving spouse and/or any children who are under 21 or are blind or disabled. Further, when a lien has been imposed on an individual's home, the State may not foreclose on the property if: a) a sibling residing in the home has lived there for at least 1 year prior to the beneficiary's institutionalization; or b) a beneficiary's adult child residing in the home has lived there continuously for at least 2 years prior to the beneficiary's admission to the nursing home and was providing care enabling the individual to delay institutionalization. The lien provisions allow States to recoup certain expenses only when the beneficiary no longer needs the resources.

Approximately half the States provide for recovery from estates of beneficiaries who were 65 or older at the time the service was rendered. Three States—Alabama, Connecticut and Maryland—have implemented the provision allowing liens to be placed on homes.[39]

V. OTHER CONDITIONS AND CRITERIA

A. Citizenship

1. GENERAL REQUIREMENTS

A State's Medicaid program must cover otherwise eligible residents if they are either citizens or aliens lawfully admitted for permanent residence or permanently residing in the United States under color of law (e.g., certain aliens admitted pursuant to the discretionary authority of the Attorney General).

A State's Medicaid plan is also required to cover treatment for emergency medical conditions for illegal aliens who otherwise meet the program's eligibility criteria. An emergency medical condition is defined as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Effective October 1, 1988, all Medicaid applicants must declare in writing, under penalty of perjury, that they are a citizen or national of the U.S., or an alien in a satisfactory immigration status. In addition, States are required to verify with the Immigration and Naturalization Service (INS), the immigration status of all aliens applying for Medicaid through the INS's designated system, Systematic Alien Verification for Eligibility (SAVE). This requirement does not apply to aliens seeking treatment for emergency medical conditions.

2. LAWFUL TEMPORARY RESIDENT ALIENS

The Immigration Reform and Control Act of 1986 (IRCA, Public Law 99–603) provides that aliens who have lived continuously in the U.S. since January 1, 1982 may apply for legalization. If their status is adjusted to lawful temporary resident status (LTR), they are not immediately eligible for Medicaid unless the following conditions are met. They must meet all the financial and categorical criteria for Medicaid coverage. Further, they must be under 18, or a Cuban-Haitian entrant, or aged, or blind, or disabled as defined under the SSI program.

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[39] Medicaid Eligibility for the Elderly in Need of Long Term Care, p. 64–67.

An LTR alien who meets the financial and categorical criteria, but does not fall into one of these specified groups, is only eligible for emergency services or services for pregnant women. These persons may be eligible for the full range of benefits beginning 5 years after the date they are granted LTR status.

3. REFUGEES

Refugees are aliens admitted to the United States for permanent residence. States are reimbursed by the Federal Government for 100 percent of their non-Federal costs for providing medical assistance to refugees during their first 24 months in the U.S. Refugees otherwise qualified for Medicaid may receive benefits under this program. Needy refugees ineligible for Medicaid may receive "refugee medical assistance." During the first 18 months, benefits are similar to those provided under Medicaid. During the 19th to 24th months benefits are similar to those otherwise available to needy residents in the State.

In fiscal year 1987, $28 million was paid under Medicaid for services to refugees.[40]

B. Residence

A State's Medicaid program must cover otherwise eligible residents of the State. An individual is generally considered a resident of a State if he or she is living in it with the intention of remaining there permanently or indefinitely. Eligibility may not be denied because an individual has not resided in the State for a specified period or because the individual is temporarily absent from the State.

A State is required to reimburse for services provided to its residents in another State in the following circumstances:

—Medical services are needed because of an emergency;

—Medical services are needed because the beneficiary's health would be endangered if he were required to travel to his State of residence;

—The State determines, on the basis of medical advice, that the needed medical services or necessary supplementary resources are more readily available in another State; or

—It is general practice for beneficiaries in a particular locality to use medical resources in another State.

C. Homeless

Homelessness does not automatically qualify an individual for Medicaid. A homeless person must still meet the program's eligibility criteria. However, a State may not exclude from coverage any otherwise eligible individual who resides in the State, regardless of whether or not the residence is maintained permanently or at a fixed address. States are required to provide a method of making eligibility cards available to eligible individuals who do not reside in a permanent dwelling or do not have a permanent home or mailing address.

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[40] Telephone conversation with Dept. of Health and Human Services, August 1988. Information is not available on the number of refugees receiving covered services. As of September 30, 1987, 56,148 AFDC-related persons and 4,567 SSI-related persons were eligible for, though not necessarily, receiving Medicaid services.

CHAPTER III. SERVICES [1] [2]

SUMMARY

State Medicaid programs provide payments for a specified group of medical services when these are provided to program beneficiaries. As noted in the previous chapter, within Federal guidelines, each State defines the eligible population. Similarly, within Federal guidelines, each State defines its own benefit package. Thus, there is considerable variation among the States in types of services covered and the amount of care provided under specific service categories.

Medicaid law draws a distinction between services States are required to cover and those they may elect to cover. All States are required to offer coverage for a core group of services (including hospital and physicians' services) provided to the categorically needy. These services are referred to as "mandatory services." In addition, States may offer coverage to the categorically needy for a broad range of additional services. These services are referred to as "optional services." [3] Federal law also places certain requirements on the types of services States are required to cover if they have elected to have a medically needy program. These requirements are different from those applicable for the categorically needy. The services States cover under their Medicaid plans are generally medical in nature. Personal care or supportive services are generally not included unless they are provided under a waiver.

States may place certain limits on the coverage of all services. For example, they may place limits on the number of covered hospital days [4] or the number of covered physician visits.

Despite this flexibility, States do have to meet the following four additional requirements in designing their benefit packages:

—*Amount, duration, and scope.* Each covered service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. The State may not arbitrarily deny or reduce the amount, duration, or scope of services solely because of the type of illness or condition. The State may place appropriate limits on a service based on such criteria as medical necessity.[5]

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[1] This chapter was written by Jennifer O'Sullivan.

[2] The discussion in this chapter is based on the requirements contained in Federal law (section 1905 of the Social Security Act) and regulations (42 C.F.R. Part 440).

[3] The distinction between mandatory and optional services may not necessarily reflect the relative importance of a particular service for a particular beneficiary.

[4] Public Law 100–360 prohibits States (effective July 1, 1989) from imposing limits on the number of covered hospital days with respect to infants receiving services in hospitals serving a disproportionate number of low income patients.

[5] The Medicaid law authorizes Federal matching for "necessary medical services." It also requires States to provide methods and procedures to safeguard against unnecessary utilization of care and services. (See Chapter VI). Unlike Medicare, the Medicaid statute does not contain a specific exclusion of services not "medically necessary" for diagnosis and treatment.

- *Comparability.* The services available to any categorically needy beneficiary in a State must be equal in amount, duration, and scope to those available to any other categorically beneficiary in the State. Similarly, services available to an individual in a covered medically needy group must be equal in amount, duration, and scope to those available to all persons in the covered medically needy group.
- *Statewideness.* Generally, a State plan must be in effect throughout an entire State, that is the amount, duration, and scope of coverage must be the same statewide.
- *Freedom-of-Choice.* Beneficiaries may obtain services from any institution, agency, pharmacy, person, or organization that undertakes to provide the services and is qualified to perform the services.

The Secretary may waive applicability of these requirements under certain circumstances.[6]

States are permitted to impose nominal cost-sharing charges, with certain major exceptions, in connection with the use of covered services.

I. Required Coverage

All States are required to offer coverage to the categorically needy for a specified group of services which are referred to as "mandatory services."

The following are mandatory services:

- inpatient hospital services,
- outpatient hospital services,
- rural health clinic services,
- other laboratory and X-ray services,
- skilled nursing facility (SNF) services for individuals 21 or older,
- early and periodic screening, diagnosis and treatment (EPSDT) services for individuals under age 21,
- physicians' services,
- home health services for any individual entitled to SNF care, and
- nurse-midwife services (to the extent nurse midwives are authorized to practice under State law or regulation).

States may also offer coverage to the categorically needy for any of a broad range of additional services which are referred to as "optional services." Optional services include such items as prescribed drugs, dental services, intermediate care facility (ICF) services, clinic services, eyeglasses, and physical therapy. (See section B in this chapter for a description of both mandatory and optional services.)

Federal law also places certain requirements on the types of services States are required to cover if they have elected to have a medically needy program. These requirements are different from those applicable to the categorically needy.[7] States having medically needy programs are required, at a minimum, to offer the following:

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[6] See discussion of waivers in Chapter V.

[7] The labels "mandatory" and "optional" services are sometimes used when describing the benefit package made available to the medically needy population.

- —Prenatal and delivery services for pregnant women;
- —Ambulatory services for individuals under 18 and individuals entitled to institutional services;
- —Home health services for individuals entitled to skilled nursing facility services; and
- —If the State provides coverage for medically needy persons over age 65 or under 21 in institutions for mental diseases or coverage for medically needy in intermediate care facilities for the mentally retarded, it is required to cover either the same services as those which are mandatory for the categorically needy or alternatively the care and services listed in 7 of the 20 paragraphs in the law defining covered services.

The coverage available to the categorically needy may not be less than that offered to the medically needy. States do, however, have the option of offering a more restrictive package for this latter group.

II. Covered Services

This section includes a brief description of the types of services covered under State Medicaid programs. The first subsection describes the so-called mandatory services, while the second section describes the so-called optional services.

A. MANDATORY SERVICES

The following services are "mandatory services" and are defined in law and regulations as follows:

- —*Inpatient hospital services* (other than services in an institution for mental diseases). Federal regulations specify that: (1) the facility must be licensed or formally approved as a hospital by an officially designated authority for State standard-setting; (2) the facility must meet the requirements for participation in Medicare; (3) the care and treatment of inpatients must be under the direction of a physician or dentist; and (4) the facility must have in effect an approved utilization review plan, applicable to all Medicaid patients (unless a waiver has been granted by the Secretary).
- —*Outpatient hospital services.* Federal regulations specify that: (1) these services must be provided under the direction of a physician or dentist; (2) the facility must be licensed or formally approved as a hospital by an officially designated authority for State-standard setting; and (3) the facility must meet the requirements for participation in Medicare.
- —*Rural Health Clinic (RHC) Services.* A RHC is a facility providing health services in a rural area with a shortage of personal health services or a shortage of primary medical care manpower. RHC services are mandatory consistent with State law permitting such services. Each RHC must be under the medical direction of a physician and must have a nurse practitioner or physician assistant on its staff. Services may be furnished by a physician, physician assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner. Part-time or inter-

mittent visiting nurse care and related medical supplies are included if the Secretary determines there is a shortage of home health agencies in the area, the services are furnished by nurses employed by the clinic, and the services are furnished under a written plan of treatment to a homebound recipient.[8]

—*Other Laboratory and X-Ray Services.* These are professional and technical laboratory and radiologic services which are: (1) ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law or ordered and billed by a physician but provided by an independent laboratory; (2) provided in an office or similar facility other than a hospital outpatient department or clinic; and (3) provided by a laboratory that meets the requirements for participation in Medicare.

—*Skilled Nursing Facility (SNF) Services.* SNFs provide services to persons who need skilled nursing or skilled rehabilitation services on a daily basis. Such daily skilled services are those which as a practical matter can only be provided in a SNF on an inpatient basis. SNF services are those that are needed on a daily basis and provided on an inpatient basis. Services must be provided by a facility or distinct part of a facility that is certified to meet participation requirements. Further, the services must be ordered by and be under the direct supervision of a physician.

SNF services, other than services in an institution for mental disease, are mandated for individuals age 21 or older.

—*Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services.* EPSDT services consist of screening and diagnostic services to determine physical or mental defects in beneficiaries under age 21 and health care, treatment and other measures to correct or ameliorate any defects or chronic conditions discovered. States are required to provide screening to each eligible beneficiary who requests it. Screenings are regularly scheduled examinations and evaluations of the general physical and mental health, growth, development and nutritional status of such individuals. As a minimum, these screenings must include: comprehensive health and developmental history; comprehensive unclothed physical exam; appropriate vision testing; appropriate hearing testing; appropriate laboratory tests; and dental services furnished by direct referral to a dentist for diagnosis and treatment for children 3 and over.

EPSDT services must include the following diagnosis and treatment services even if not otherwise covered under the State's Medicaid plan: diagnosis and treatment for defects in vision and hearing, including eyeglasses and hearing aids; dental care at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health; and appropriate immunizations. The State may include additional services under its EPSDT program, even if such services are not provided (or provided to a lesser degree) to other program eligibles.

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[8] As of Mar. 31, 1986, the following States did not include coverage for RHC services: Hawaii, Massachusetts, Montana, Nebraska, New Jersey, and the District of Columbia. (Source: U.S. Department of Health and Human Services. Health Care Financing Administration (HCFA). Analysis of State Medicaid Program Characteristics, 1986. Baltimore, Maryland, Aug. 1987. p. 44.)

Each State is required to implement a periodicity schedule for screening services which specifies screening services applicable at each stage of the child's life beginning with a neonatal exam.

- *Family Planning Services.* This category includes services and supplies for women of child bearing age, including minors who can be considered to be sexually active, who desire such services and supplies.[9] (Abortions are excluded from family planning services).[10]
- *Physicians' Services.* Physicians' services must be furnished by or under the personal supervision of a licensed doctor of medicine or osteopathy. and must be within the scope of practice of medicine or osteopathy as defined under State law. The services are covered whether provided in the office, patient's home, a hospital, SNF, or elsewhere. Also included are medical and surgical services furnished by a dentist: (1) to the extent such services may be performed under State law either by a physician or by a doctor of dental surgery or dental medicine; and (2) if they would be covered as a physician's service if furnished by a physician.
- *Home Health Services.* These services must be provided to any individual entitled to SNF care. They are defined as services provided at an individual's place of residence (not including a hospital, SNF, or ICF except for home health services in an ICF that are not required to be provided by the facility). Services must be provided on a physician's orders as part of a written plan of care that is reviewed by a physician every 60 days. Home health services include three mandatory services (part-time nursing, home health aide, and medical supplies and equipment) and one optional service (physical therapy, occupational therapy, and speech pathology and audiology services) as follows:
    - *Part-Time Nursing.* These are nursing services provided on a part-time or intermittent basis by a home health agency. If there is no agency in the area, the services may be provided by a registered nurse who is currently licensed to practice in the State, receives written orders from the patient's physician, documents the care and services provided, and has had orientation to acceptable clinical and administrative record keeping from a health department nurse.
    - *Home-Health Aide.* These services are provided by a home health agency.
    - *Medical Supplies and Equipment.* These are items suitable for use in the home.

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[9] Medicaid coverage for sterilizations is only available if: the individual is 21, is not mentally incompetent, and has voluntarily given informed consent for the procedure. Hysterectomies are not covered if the purpose of the procedure is to render the woman permanently incapable of reproducing.

[10] As noted, abortions are not covered as family planning services. Federal matching payments for abortions have been limited, by language in the Department's appropriations bills, to cases where the life of the mother is in danger.

—*Physical Therapy, Occupational Therapy, and Speech Pathology and Audiology Services.* These services may be provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services.

—*Nurse-Midwife Services.* States are required to provide coverage for these services to the extent the nurse midwife is authorized to practice under State law or regulation. The services are covered whether or not the nurse-midwife is under the supervision of or associated with a physician or other health care provider.[11]

B. OPTIONAL SERVICES

In addition to those services which have been labelled mandatory, States may offer coverage for any of a broad range of other medical services which are referred to as optional services. HCFA has identified a total of 32 optional service categories. Table III-1 shows, effective October 1987, the number of States electing to provide each service for their categorically needy population, and, if applicable, for both their categorically needy and medically needy populations. As can be seen from the table, virtually all States cover prescription drugs, ICF services, and optometrists' services while a more limited number of States have elected to provide coverage under some other service categories, for example, preventive services. Table III-2 shows, as of October 1987, the optional services covered by each State both for their categorically needy and, if applicable, their medically needy populations.

Table III-1.—OPTIONAL MEDICAID SERVICES AND NUMBERS OF STATES [1] OFFERING EACH SERVICE AS OF OCTOBER 1, 1987

Service	States offering service to categorically needy only	States offering service to both categorically and medically needy	Total
Podiatrists' services	10	32	42
Optometrists' services	15	36	51
Chiropractors' services	8	20	28
Other practitioners' services	9	26	35
Private duty nursing	5	15	20
Clinic services	16	36	52
Dental services	14	35	49
Physical therapy	8	27	35
Occupational therapy	4	21	25
Speech, hearing and language disorder	7	26	33
Prescribed drugs	14	37	51
Dentures	10	27	37
Prosthetic devices	13	36	49
Eyeglasses	13	34	47
Diagnostic services	4	17	21
Screening services	4	14	18
Preventive services	4	17	21
Rehabilitative services	9	28	37

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[11] A Nov. 1987 report by the General Accounting Office (GAO) showed that all States had a law or regulation allowing nurse midwives to practice. As of Sept. 1987, 44 States covered nurse midwife services under their Medicaid programs; HCFA was working with the other 6 States to bring their plans into compliance. (U.S. General Accounting Office. Report to the Honorable Daniel K. Inouye. Medicaid: Use of Certified Nurse Midwives. GAO/HRD-88-25; Nov. 1987.)

Table III-1.—OPTIONAL MEDICAID SERVICES AND NUMBERS OF STATES [1] OFFERING EACH SERVICE AS OF OCTOBER 1, 1987—Continued

Service	States offering service to categorically needy only	States offering service to both categorically and medically needy	Total
Services for age 65 or older in mental institution:			
A. Inpatient hospital services	18	24	42
B. SNF services	10	14	24
C. ICF services	11	18	29
Intermediate care facility services	21	29	50
ICF for mentally retarded	19	29	48
Inpatient psychiatric services for under age 22	10	27	37
Christian science nurses	1	4	5
Christian science sanitoria	4	12	16
SNF for under age 21	17	30	47
Emergency hospital services	14	30	44
Personal care services	8	18	26
Transportation services	12	33	45
Case management services	1	14	15
Hospice services	0	6	6

[1] Includes the territories. Thus, maximum number is 56.

Source: U.S. Department of Health and Human Services.

Table III-2.—MEDICAID SERVICES STATE BY STATE

October 1, 1987

Basic Required Medicaid Services

Medicaid recipients receiving federally supported financial assistance must receive at least these services:

- Inpatient hospital services
- Outpatient hospital services
- Rural health clinic services
- Other laboratory and X-ray services
- Skilled nursing facility services and home health services for individuals 21 and older
- Early and periodic screening, diagnosis, and treatment for individuals under 21
- Family planning services and supplies
- Physician services
- Nurse Midwife services

Federal financial participation is also available to States electing to expand their Medicaid Programs by covering additional services and/or by including people eligible for medical but not for financial assistance. For the latter group, States may offer the services required for financial assistance recipients or may substitute a combination of seven services.

Definitions and limitations on eligibility and services vary from State to State. Details are available from local welfare offices and State Medicaid agencies.

Services provided only under the Medicare buy-in or the screening and treatment program for individuals under 21 are not shown on this chart.

Optional Services in State Medicaid Programs

● CN[2]
+ Both CN and MN[3]

FMAP[1]	Basic Required Medicaid Services See Above		Podiatrists' Services	Optometrists' Services	Chiropractors' Services	Other Practioners' Services	Private Duty Nursing	Clinic Services	Dental Services	Physical Therapy	Occupational Therapy	Speech, Hearing and Language Disorder	Prescribed Drugs	Dentures	Prosthetic Devices	Eyeglasses	Diagnostic Services	Screening Services	Preventive Services	Rehabilitation Services	Services for Age 65 or Older in Mental Institution			Intermediate Care Facility Services	ICF for Mentally Retarded	Inpatient Psychiatric Services for under Age 22	Christian Science Nurses	Christian Science Sanitoria	SNF for under Age 21	Emergency Hospital Services	Personal Care Services	Transportation Services	Case Management Services	Hospice Services	Total Additional Services	
																					A. Inpatient Hospital Services	B. SNF Services	C. ICF Services													
73.29	●	Alabama		●				●					●		●	●		●	●			●	●	●	●				●	●	●	●			15	AL
50.00	●	Alaska		●	●			●	●	●	●	●			●	●					●			●	●	●			●	●	●	●			17	AK
50.00		American Samoa[4]																																		AS
62.12	●	Arizona[5]	●	●				●	●	●		●	●	●	●	●														●		●			12	AZ
74.21	+	Arkansas		+	+	+		+	+				+	+	+	+				+	+	●	●	●	●	+			●	+	●	+	+		21	AR
50.00	+	California	+	+	+	+	+	+	+	+	+	+	+	+	+	+				+	+	+	+	+	+	+	+	+	+	+		+			26	CA
50.00	●	Colorado	●	●		●		●	●				●			●					●	●	●	●	●	●			●	●		●			16	CO
50.00	+	Connecticut	+	+	+	+	+	+	+	+		+	+	+	+	+	+	+	+	+	+			+	+	+		+	+			+			24	CT
51.90	●	Delaware	●	●		●	●	●					●		●		●				●	●	●	●	●				●	●		●			16	DE
50.00	+	D.C.	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+			+	+	+				26	DC
55.39	+	Florida	+	+		+		+	+			+	+	+	+	+				+	●			●	●					+		+		+	17	FL
63.84	+	Georgia	+	+		+		+	+				+	+	+	+		+						+	+				+			+	+		15	GA
50.00	●	Guam		●				●	●				●			●														●					6	GU
53.71	+	Hawaii	+	+		+		+	+	+	+	+	+	+	+	+	+	+	+	+				+	+	+			+	+		+			22	HI
70.47	●	Idaho	●	●	●	●		●	●				●							●			●	●	●				●	●		●			14	ID
50.00	+	Illinois	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	+	+	+	+	+	+	+			+	+		+			26	IL
63.71	●	Indiana	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			●	●	●	●	●	●	●	●	●			28	IN
62.75	+	Iowa	+	+	+	+		+	+	+	+	+	+	+	+	+	+		+	+	●			●	●	●			+	+					22	IA
55.20	+	Kansas	+	+	+	+		+	+	+	+	+	+		+	+				+	+		+	+	+	+			+	+	+				21	KS
72.27	+	Kentucky	+	+		+		+	+	+	+	+	+		+		+	+	+	+	+	+	+	+	+	+			+	+		+		+	24	KY
68.26	+	Louisiana		+				+	+				+	+	+					+	●			●	●	●			●			+	+		14	LA
67.08	+	Maine	+	+	+	●	+		+	+	+	+	+	+	+	+	+	+	+	+	+			+	+	+	+	+	+		+	+	+		27	ME
50.00	+	Maryland	+	+				●	●	+		+	+	●	+	+					+			+	+	+			+	+	●	+			18	MD
50.00	+	Massachusetts	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		31	MA

56.46	+	Michigan	+	+	+	+		+	+	+	+	+	+	+	+	+	+			+	+	+	+	+	+	+		+	+	+	+	+	+	+	28	MI
53.98	+	Minnesota	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	+	+	+	+		+	30	MN
79.65	●	Mississippi		●				●	●				●		●	●			●	●				●	●			●	●	●		●			14	MS
59.27	●	Missouri	●	●				●	●				●	●	●	●				●	●			●	●	●					●				14	MO
69.40	+	Montana	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+			+	+	+	+			27	MT
59.73	+	Nebraska	+	+	+	+	+	+	+	+		+	+	+	+	+					+	+	+	+	+	+			+	+	+				22	NB
50.25	●	Nevada	●	●	●	●	●	●	●	●	●	●	●	●	●	●				●	●	●	●	●	●				●	●	●	●			24	NV
50.00	+	New Hampshire	+	+	+	+	+	+	+	+	+	+	+		+	+	+	+	+	+	+		+	+	+		+	+	+	+	+	+	+		28	NH
50.00	+	New Jersey[7]	+	+	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	●	●	●	●	●	●		●	●	+	+	+			28	NJ
71.52	●	New Mexico	●	●		●		●	●	●			●	●	●	●				●				●	●				●	●		●			16	NM
50.00	+	New York	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+			+	+	+			+	+	+	+			25	NY
68.68	+	North Carolina	+	+	+			+	+				+	+	+	+	+	+	+	+	+		+	+	+	+			+		+	+	+		22	NC
64.87	+	North Dakota	+	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+			+	+	+			+	+		+		+	25	ND
50.00	+	N. Mariana Islands		+				+	+	+			+	+	+	+														+	+	+			11	NMI
59.10	●	Ohio	●	●	●	●	●	●	●	●	●	●	●	●	●	●				●	●	●	●	●	●	●		●	●	●		●	●		26	OH
63.33	+	Oklahoma	+	+		+		+	+				+		+	+		●		+	●			●	●	+			●		+	+			17	OK
62.11	+	Oregon	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	+	●			●	+	●		+	●	+	+	+			26	OR
57.35	+	Pennsylvania	+	+	+			+	+				●	●	●	+					+	+	+	+	+	+				+		+			17	PA
50.00	+	Puerto Rico[6]						+																											1	PR
54.86	+	Rhode Island	●	+					+				+	+	+	●				+	+	+	+	+	+	+			+			+	+		17	RI
73.49	+	South Carolina	+	+				+	+				+		+	+				+	+	+	+	+	+	+			+	+		+			17	SC
70.43	●	South Dakota			●			●	●	●		●	●	●	●						●	●	●	●	●				●	●	●	●			17	SD
70 64	+	Tennessee						+	+				+		+	+					●	●	●	●	●	+		+	+	+		+			15	TN
56.91	+	Texas	+	+	+	+							+		+	+				+				+	+			+	+	+	+	+			15	TX
73.73	+	Utah	+	+		+		+	+	+		+	+	+	+	+					+	+	+	+	+	+			+	+	+	+	+		22	UT
66.23	+	Vermont	+	+	+	+		+	+	+	+	+	+	+	+	+				+	+		+	+	+	+			+	+		+	+	+	24	VT
50.00	+	Virgin Islands[6]						+																											1	VI
51.34	+	Virginia	+	+				+	+	+	+	+	+			+					●	●	●	+				+	+	+		+			17	VA
53.21	+	Washington	+	+	●	+	+	+	+	+	+	●	+	+	+	+	●		+	+	+	+	+	+	+	+			+	+			+		26	WA
74.84	+	West Virginia	+	+	+	+	+	+	+	+		+	+	+	+	+								+	+	+			+	+		+	+		20	WV
58.98	+	Wisconsin		●	●	●	●	+	●	+	+	+	+	●	+	●	●	●	●	●	●			+	+	●		+	+	●	+	+	+		27	WI
57.96	●	Wyoming		●				●		●					●					●	●			●					●						8	WY
●	15	●	10	15	8	9	5	16	14	8	4	7	14	10	13	13	4	4	4	9	18	10	11	21	19	10	1	4	17	14	8	12	1	0		
+	40	+	32	36	20	26	15	36	35	27	21	26	37	27	36	34	17	14	17	28	24	14	18	29	29	27	4	12	30	30	18	33	14	8		
	55	Total	42	51	28	35	20	52	49	35	25	33	51	37	49	47	21	18	21	37	42	24	29	50	48	37	5	16	47	44	26	45	15	8		

[1] Federal Medical Assistance Percentage (FMAP): Rate of Federal Financial Participation in a States Medical Assistance Program under Title XIX of the Social Security Act. Effective October 1, 1987 through September 30, 1988 (Fiscal Year 1988).

[2] Categorically Needy: Individuals receiving federally-supported financial assistance.

[3] Medically Needy: Individuals who are eligible for medical but not for financial assistance.

[4] American Samoa operates a special Medicaid waivered program.

The data shown were supported by individual Regional Offices and compiled by the Office of Intergovernmental Affairs.

HCFA Pub. No. 02155-88

[5] Arizona operates a federal assistance program under a Section 1115 Demonstration Project

[6] All services are provided through public health facilities.

[7] Services indicated as available to the Medically Needy are not available to all Medically Needy Groups.

U.S. Department of Health and Human Services
Health Care Financing Administration
Office of Intergovernmental Affairs

Optional services are defined in law and regulations as follows:[12]

- *Medical Care or Any Other Type of Remedial Care Recognized Under State Law, Furnished by Licensed Practitioners Within the Scope of Their Practice as Defined by State Law.* Included within this definition are services provided by chiropractors, podiatrists, optometrists, and psychologists. Coverage for care provided by chiropractors is limited, by regulation, to treatment by means of manual manipulation of the spine that the chiropractor is legally licensed by the State to perform.
- *Private Duty Nursing Services.* These are nursing services for persons who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of a hospital or SNF. The services must be provided by a registered nurse or licensed practical nurse, be under the direction of a physician, and be provided to an individual in his home, hospital or SNF.
- *Clinic Services.* Clinic services are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that are provided to outpatients under direction of a physician or dentist without regard to whether the clinic itself is administered by a physician. The services are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Clinic services for homeless may be provided outside the clinic by clinic personnel.

  Clinics providing covered services may provide general health care services or may focus on specific services, e.g., mental health services. Services provided in ambulatory surgical centers (ASCs) may be covered either as clinic services or as "other medical care recognized under State law."
- *Dental Services.* Dental services are defined as diagnostic, preventive or corrective procedures provided by or under the supervision of a dentist in the practice of his profession including treatment of the teeth and associated structures of the oral cavity and treatment of disease, injury, or impairment that may affect the oral or general health of the recipient.
- *Physical Therapy and Related Services.* This category includes the following services (including necessary equipment and supplies):
  - *Physical Therapy.* Physical therapists are responsible for evaluating physical capacities and limitations and for administering treatments designed to alleviate pain, correct or minimize deformity, increase strength and mobility, and improve general health. Covered physical therapy services are those which are prescribed by a physician and provided by or under the direction of a qualified physical therapist. A qualified therapist is one who is licensed by the State, where applicable, and a graduate of a physical therapy program approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association, or its equivalent.

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[12] The services listed in this section are generally listed in the order they appear in the law and on HCFA's chart of optional Medicaid services (table III-2).

- *Occupational Therapy.* Occupational therapy services are designed to assist individuals to achieve or maintain their capacity to function in activities of daily living at a level which allows as much independence as possible. These are services prescribed by a physician and provided by or under the direction of a qualified occupational therapist. A qualified therapist is one who is registered by the American Occupational Therapy Association or who is a graduate of an occupational therapy program approved by the Council on Medical Education of the American Medical Association and engaged in supplemental clinical experience required by the American Occupational Therapy Association.
- *Services for Persons with Speech, Hearing and Language Disorders.* These are diagnostic, screening, preventive or corrective services, provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician. A speech pathologist or audiologist is one who has a certificate of clinical competence from the American Speech and Hearing Association, has completed the equivalent educational requirements and work experience, or has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

—*Prescribed Drugs.* Prescribed drugs are simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease or health maintenance. They must be: (1) prescribed by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined and limited by Federal and State law; (2) dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and (3) dispensed on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

—*Dentures.* These must be made by or under the direction of a dentist to replace a full or partial set of teeth.

—*Prosthetic Devices.* These are replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law to: (1) artificially replace a missing portion of the body; (2) prevent or correct a physical deformity or malfunction; or (3) support a weak or deformed portion of the body. Within this category, States may include hearing aids, orthopedic shoes, pacemakers, and durable medical equipment (e.g., wheelchairs).

—*Eyeglasses.* These are lenses, including frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or by an optometrist.

—*Diagnostic, Screening, Preventive, and Rehabilitative Services.* Diagnostic services are medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of practice under State law, to enable him to identify the existence, nature, or extent of illness, injury or other health deviation.

Screening services means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies those suspected of having certain diseases.

Preventive services are those provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law to: (1) prevent disease, disability, and other health conditions or their progression; (2) prolong life; and (3) promote physical and mental health and efficiency.

Rehabilitation services means (except as otherwise included under another service definition) medical or remedial services recommended by a physician or other licensed practitioner of the healing arts (within the scope of his or her practice under State law) for maximum reduction of physical or mental disability and restoration of a beneficiary to the best possible functional level.

—*Inpatient Hospital Services, SNF Services and ICF Services for Individuals Age 65 or Older in Institutions for Mental Diseases.* A State may choose to provide services at any of these three levels of care to persons 65 or over in a mental institution. An institution for mental disease is defined as one that meets Medicare requirements except that the requirement for utilization review may be waived. Covered services include diagnosis, treatment and care of individuals with mental diseases including medical care, nursing care and related services.

—*Intermediate Care Facility (ICF) Services.* ICF services (other than those provided in a mental institution) are those provided in a facility which fully meets the requirements for State licensure to provide on a regular basis, health-related services to individuals who do not require hospital or SNF care, but whose mental or physical condition requires services that are above the level of room and board and can be made available only through institutional facilities. The ICF must meet specified certification standards. ICF services may be provided by a distinct part of a facility other than an ICF if it meets requisite standards.

—*Services in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).* ICF services may include services in an institution for the mentally retarded or persons with related conditions if: (1) the primary purpose of the institution is to provide health or rehabilitative services for such persons; (2) the institution meets requisite certification requirements; and (3) the individual is receiving active treatment. The institution must provide in a protected residential setting ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability.

Each client must receive a continuous active treatment program which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward: (1) the acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (2) the prevention or deceleration of regression or loss of current optimal functional status. Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

—*Inpatient Psychiatric Hospital Services for Individuals Under Age 21.* These are inpatient services provided in a psychiatric hospital or distinct part thereof. The services must be provided under the direction of a physician by an accredited facility or accredited program in the facility. A team, consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and treatment, must certify that services are necessary on an inpatient basis and can reasonably be expected to improve the patient's condition to the extent that eventually such services will no longer be necessary. Active treatment requirements specify that services must be provided pursuant to a professionally developed and supervised individual plan of care which is designed to achieve the beneficiary's discharge from the facility at the earliest practical time.

If the individual is receiving services on the date he or she turns 21, coverage may be extended until the individual no longer needs such care, or turns 22, whichever is earlier.

—*Hospice Care.* States may offer coverage for hospice care provided to a terminally ill individual who has voluntarily elected to have payment made for such care in lieu of having payment made for certain other services. The definitions for covered services and the definition of a hospice program are the same as those under Medicare. Covered services include nursing care, physical or occupational therapy or speech language pathology, medical social services under the direction of a physician, home health aide and homemaker services, medical supplies and the use of medical appliances, physicians' services, short-term inpatient care and counseling. The services must be provided under a written plan of care established and periodically reviewed by a physician. A hospice program is a public agency or private organization which is primarily engaged in providing such services directly or under arrangement, makes services available as needed on a 24 hour basis, and meets applicable licensing requirements. Beneficiaries' elections of hospice care may be for a period or periods established by the State and may be revoked by them.

—*Case-Management Services.* Case management services are defined as services which will assist eligible individuals in gaining access to needed medical, social, educational and other services. States may provide these services without regard to the statewideness requirement or the requirement that Medicaid services be equal in amount, duration, and scope for all categorically needy beneficiaries. The provision of case management services may not restrict the beneficiaries' freedom of choice to select a provider of services.

A State may limit the provision of case management services to individuals with acquired immune deficiency syndrome (AIDS), or with AIDS-related conditions, or with either. A

State may also limit the provision of case management services to individuals with chronic mental illness.

—*Respiratory Care Services.* Respiratory therapists are responsible for administering oxygen and other gases and mists for medical purposes. The therapist sets up the necessary equipment and administers prescribed doses of therapeutic gases and aerolized drugs to patients with such diseases such as emphysema, tuberculosis, cardiac conditions and asthma. Respiratory care services are defined as those which are provided on a part-time basis in the home of an individual by a respiratory therapist or other health care professional trained in respiratory therapy, as determined by the State. Respiratory care payments are those that are not otherwise included within other items and services for such persons under the State's program. Covered individuals must: (1) be medically dependent on a respirator for life support at least 6 hours a day; (2) have been so dependent as inpatients in hospitals, SNFs or ICFs for at least 30 consecutive days, or the maximum number of days authorized under the State plan, whichever is less; (3) require respiratory care on an inpatient basis and be eligible for Medicaid for the inpatient care; and (4) have adequate social support services to be cared for at home and wish to be cared for at home. States are permitted to limit coverage of respiratory services to ventilator-dependent individuals.

—*Any Other Medical Care or Remedial Care Recognized under State Law, Specified by the Secretary.* The following items have been specified by the Secretary:

—*Services of Christian Science Sanitoria Nurses.* These are services provided by nurses who are listed and certified by the First Church of Christ, Scientist, Boston, Massachusetts.

—*Services in Christian Science Sanitoriums.* These are services provided in sanitoriums operated by or listed and certified by the First Church of Christ, Scientist, Boston, Massachusetts.

—*Skilled Nursing Facility Services for Individuals Under Age 21.*

—*Emergency Hospital Services.* These are services that are necessary to prevent the death or serious impairment to the health of a beneficiary and because of the threat to life or health, necessitates the use of the most accessible hospital available that is equipped to furnish the services. The services are covered even if the hospital does not meet Medicare conditions of participation or the definition of inpatient or outpatient hospital services.

—*Personal Care Services in a Beneficiary's Home.* These are services which are prescribed by a physician in accordance with the recipient's plan of care and provided by an individual who is qualified to provide the services, supervised by a registered nurse, and not a member of the beneficiary's family. A State which has been granted a home and community based services waiver may define personal care services differently for purposes of that waiver.

—*Transportation.*[13] This includes expenses for transportation and other related travel expenses determined to be necessary to secure medical examinations and treatment. Covered services include only those furnished by a provider to whom a direct vendor payment can be made, for example, an ambulance company. (Other services may be covered as administrative expenses.) Travel expenses include the costs of transportation, the cost of meals and lodging enroute and while receiving medical care, and the cost of an attendant to accompany the beneficiary including his or her meals, lodging, and transportation.

The Omnibus Budget Reconciliation Act of 1987, Public Law 100-203 (OBRA87) eliminated, effective October 1, 1990, the current law distinction between SNFs and ICFs participating in Medicaid. These facilities will all be referred to as nursing facilities and the services provided in them referred to as nursing services. Nursing services, including what are now optional ICF services, will be mandatory. On and after October 1, 1990, all nursing facilities participating in Medicaid will have to meet a single set of requirements relating to the provision of services, resident's rights, administration, and other matters. OBRA87 made no changes in Medicaid law requirements for ICF/MRs or institutions for mental disease.

III. Requirements Applicable for All Services

States have to meet four additional requirements in designing their benefit packages. These relate to: amount, duration, and scope of services; comparability; statewideness; and freedom of choice. The Secretary may waive applicability of these requirements under certain circumstances.[14]

A. AMOUNT, DURATION, AND SCOPE

A State is required to specify the amount, duration, and scope of each service that it provides for the categorically needy and for each covered medically needy group. Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. The Medicaid agency may not arbitrarily deny or reduce coverage of a required service solely because of the diagnosis, type of illness, or condition. It may place limits on services.

B. COMPARABILITY

The services available to any categorically needy beneficiary under a State program must be equal in amount, duration, and scope to those available to any other categorically needy beneficiary in the State. Similarly, services available to an individual in a covered medically needy group must be equal in amount, duration and scope to those available to all persons in the covered medically needy group.

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[13] Federal regulations include an administrative requirement that States must specify that its Medicaid agency will assure necessary transportation for beneficiaries to and from providers. If covered as an administrative expense, Federal matching is at the appropriate administrative rate. If covered as an optional service, Federal matching is at the Federal Medical Assistance Percentage rate (see Chapter VII).

[14] See discussion of waivers in Chapter V.

The coverage available to the categorically needy may not be less than that offered to the medically needy. States do however, have the option of offering a more restrictive package for this latter group. As of March 1986, 27 of the 35 States (including D.C.) which had medically needy programs offered the same coverage of mandatory services for the medically needy as for the categorically needy. Twenty-three of the States offered the same coverage for optional services.[15]

There are a number of exceptions to the comparability requirements, primarily tied to a beneficiary's age or participation in Medicare. For example, SNF services may be limited to persons over 21. EPSDT services must be limited to persons under 21. Further, States may limit additional benefits available to dual Medicare/Medicaid beneficiaries under a buy-in agreement to persons covered by the agreement.[16]

C. STATEWIDENESS

Generally, a State plan must be in effect throughout an entire State, that is the amount, duration, and scope of coverage must be the same statewide. However, certain limited exceptions are authorized. For example, a State does not have to offer any additional services which are offered by a prepaid health plan to its enrollees, to other beneficiaries in the State. Also, a State operating a home and community based services waiver does not have to offer all services covered under the waiver to other beneficiaries.

D. FREEDOM OF CHOICE

Beneficiaries may obtain services from any institution, agency, pharmacy, person, or organization that undertakes to provide the services and is qualified to perform the services, (including an organization that provides these services or arranges for the provision of these services on a prepaid basis). This is known as the "freedom of choice" requirement. The freedom- of-choice requirement is not applicable in Puerto Rico, the Virgin Islands, and Guam. Further this requirement may be waived under certain circumstances.[17]

IV. UTILIZATION CONTROLS AND SERVICE LIMITATIONS

States have adopted various methods for attempting to control the costs of Medicaid services. Two basic approaches are employed—establishing payment limits and lowering utilization rates.[18] States may establish absolute limitations, for both mandatory and optional services, on the amount, duration, and scope of care provided under a specific service category. For example, they may establish durational limits on coverage. States may also establish certain utilization controls such as medical necessity review, prior authorization for the use of specific services, or second surgical opinion programs.

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[15] U.S. Department of Health and Human Services, HCFA, Analysis of State Medicaid Program Characteristics, 1986, p. 73.

[16] See Chapter IV for a discussion of the Medicare buy-in.

[17] See discussion of waivers in Chapter V.

[18] See Chapter IV for a discussion of payment policies.

A. HOSPITAL SERVICES

Hospital utilization controls may take several forms. One method focuses on monitoring admissions to assure that patients are only admitted when medically necessary. A second method focuses on encouraging the provision of services in outpatient settings. Another method monitors or limits the length of stay. These approaches may be combined. For example, a number of States impose a limit on the number of days of care; in some States, when this limit is reached a medical necessity or similar review is triggered.

States specify limits on the number of days of inpatient care on a per year or per spell of illness basis.[19] Some States limit coverage based on a percentile of the length-of-stay data from the Professional Activity Study (PAS) or other average length of stay measure. The PAS, which presents the average length of stay calculated by diagnosis and region, is collected and prepared by the Commission on Professional Hospital Activities. Table III–3 shows, effective December 1986 which States have elected to impose length of stay restrictions.

Table III–3.—INPATIENT HOSPITAL LENGTH OF STAY RESTRICTIONS, BY STATE, DECEMBER 1986

State	Limits on covered days					Percentile of PAS * or other related LOS	Extensions
	Number of days	Limits apply					
		Per CY	Per FY	Per admission	Per spell of illness		
Alabama	[1] 12	X					yes [1]
Alaska						75	yes [2]
Arizona [3]							
Arkansas	20		X			50	yes [4]
California [5]							
Colorado							
Connecticut						[6] 75	yes [6]
Delaware							
District of Columbia							
Florida	45		X				no
Georgia							
Hawaii							
Idaho	40		X				no
Illinois [7]							
Indiana							
Iowa							
Kansas					([8])		no
Kentucky	14			X			no
Louisiana	10	X					yes
Maine	[9] 30				X		yes [9]
Maryland						[10] X	yes [10]
Massachusetts							
Michigan							
Minnesota							
Mississippi	15		X				no
Missouri						75	yes
Montana							
Nebraska						75	yes [11]

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[19] In 1985, the Supreme Court ruled that Tennessee's action reducing the number of covered inpatient hospital days from 20 to 14 per year did not discriminate against the handicapped in violation of Section 504 of the Rehabilitation Act of 1973.

Table III-3.—INPATIENT HOSPITAL LENGTH OF STAY RESTRICTIONS, BY STATE, DECEMBER 1986—Continued

State	Limits on covered days					Percentile of PAS * or other related LOS	Extensions
	Number of days	Limits apply					
		Per CY	Per FY	Per admission	Per spell of illness		
Nevada							
New Hampshire							
New Jersey							
New Mexico							
New York	20			X			yes [12]
North Carolina							
North Dakota							
Ohio	30				X		yes [13]
Oklahoma							
Oregon	18		X				no [14]
Pennsylvania							
Rhode Island							
South Carolina							
South Dakota							
Tennessee	[15] 14		X				no
Texas	30				[16] X		no
Utah							
Vermont							
Virginia	[17] 21			[17] X			no
Washington						([18])	yes
West Virginia	60		X				no [19]
Wisconsin							
Wyoming							

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[1] Alabama: For dual eligibles under Medicare and Medicaid, Medicaid days become available only after Medicare coverage has been exhausted. (The deductible and coinsurance features of Medicare inpatient hospital coverage are not a benefit under the Medicaid program.) Five-day maximum extension for all beneficiaries, when authorized. EPSDT beneficiaries who have been hospitalized continuously for more than 30 consecutive days after they have exhausted their 12 annual days receive an additional 12 continuous days of coverage, with prior authorization. This extension policy can be repeated after additional 30-day noncovered periods.

[2] Alaska: If 75th percentile is surpassed, prior authorization must be obtained for a stay up to the 90th. Beyond the 90th percentile, prior authorization is again required.

[3] Arizona: Arizona operates a demonstration program under which contractors are at risk; thus, there is no need for the State to require covered day limits.

[4] Arkansas: Exceptions to the 20-day limit are made for all beneficiaries with life-threatening conditions and for those under 21 years of age. Extensions beyond the 50th percentile are permitted for EPSDT beneficiaries.

[5] California: Operates a selective contracting program for inpatient hospital services. There are no specific length of stay limits. However, there is pre-admission screening of all elective admissions, with follow-up reviews every 3 days.

[6] Connecticut: This is a guideline. Any stays over the 75th percentile of PAS length of stay will be reviewed by the agency against ***Acuity Evaluative Protocol*** (AEP) criteria (for conditions present in the patient). If criteria are not met, state will not pay for a longer stay.

[7] Illinois: Illinois established a selective contracting program, whereby a statewide limit of covered hospital days was set and allocated among the hospitals. An individual hospital can exceed its day limit, but once the statewide limit is reached, all hospitals receive 65 percent reimbursement for excess days.

[8] Kansas: Mother's stay for normal deliveries is limited to 2 days.

[9] Maine: This is a point at which a review is required before further coverage is allowed.

[10] Maryland: The State calculated its own average length of stay for each DRG and set a limit at 120 percent of the average length of stay. Maryland covers approved outlier cases that exceed the limit.

[11] Nebraska: Medical necessity documentation required for extensions.

[12] New York: A review for medical necessity is done prior to the 20th day and every 3 days thereafter.

[13] Ohio: Exceptions allowed when certified as medically necessary.

[14] Oregon: No extensions, with two exceptions: (1) if patient enters hospital within the allowed 18 days, he may complete his stay, and (2) a special program for spinal cord injuries in which a fixed fee is paid, regardless of length of stay.

[15] Tennessee: A 14-day limit for adults, but 20 days are covered for EPSDT beneficiaries under 21 years of age.

[16] Texas: Beneficiaries must be out of hospital 60 consecutive days between stays.

[17] Virginia: A maximum of 21 days per admission for coverage within a 60-day period for the same diagnosis, beginning with the date of first admission. Children under age 21 are exempt.

[18] Washington: The state adopted a DRG reimbursement system. Only non-DRG hospitals are subject to a 75th percentile of PAS length of stay limit.

[19] West Virginia: Sixty-day limit is absolute, with two exceptions: 1) children in foster care, and 2) children under the Handicapped Children's Services Program.

* ***Professional Activity Study*** (PAS) average length of stay, calculated by diagnosis and by region, as collected and prepared by the Commission on Professional Hospital Activities.

Source: National Governors' Association, State Medicaid Program Information Center: 1986. A Catalogue of State Medicaid Program Changes. p. 45.

As noted, a number of States which impose restrictions permit extensions of coverage under certain circumstances, for example, if medical necessity is established. An example of an alternative approach is that used in California. The state has no specific length-of-stay limits, however there is pre-admission screening of all elective admissions. (See footnotes in table III–3 for individual State requirements).

B. PHYSICIANS' SERVICES

Many States have elected to place specific limits on the number of physician visits covered by the program. These limits may be overall limits or tied to the visit site, for example limits on inpatient hospital visits, long term care facility visits, or office visits. Table III–4 shows, effective December 1986, which States imposed numerical limits on covered physician visits.

Table III–4.—LIMITATION ON NUMBER OF PHYSICIANS' VISITS, BY TYPE OF VISIT, BY STATE, DECEMBER 1986

States	Inpatient hospital visits	Long term care facility visits	Office visits	Combination of visits
Alabama	1/day: 12/CY			12/CY [1]
Alaska		1/30 days		
Arizona				
Arkansas	1/day/physician [2]		(2)	18/FY [2]
California				
Colorado				
Connecticut				
Delaware				
District of Columbia				
Florida	1/day [3]	1/month	1/provider/day [3]	
Georgia	1/day			12/yr [4]
Hawaii		2/month [5]		
Idaho				
Illinois				
Indiana				
Iowa				
Kansas	1/day [6]	1/month [6]	12/24/year [6]	
Kentucky			(7)	
Louisiana	10/CY-nonsurgery: 1/day.			8/year [8]
Maine				
Maryland				
Massachusetts	1/day	1/day	1/day	
Michigan		1/30 days		
Minnesota				
Mississippi	1/day [9]	36/year		12/FY [9]
Missouri		1 month [10]		
Montana				
Nebraska				
Nevada				2/month [11]
New Hampshire	12 procedures/yr [12]			18/FY [12]
New Jersey				
New Mexico				
New York				
North Carolina				24/year [13]
North Dakota	1/day	1/month [14]		

Table III-4.—LIMITATION ON NUMBER OF PHYSICIANS' VISITS, BY TYPE OF VISIT, BY STATE, DECEMBER 1986—Continued

States	Inpatient hospital visits	Long term care facility visits	Office visits	Combination of visits
Ohio		12/year [15]		4/provider/month [15]
Oklahoma	1/day	2/month		4/month [16]
Oregon				
Pennsylvania	$1,000/stay [17]			$500/day [17]
Rhode Island	37/stay			
South Carolina				18/year [18]
South Dakota				
Tennessee	1/day	24/FY	24/FY	
Texas				
Utah				
Vermont	1/day [19]	1/wk/month [19]	5/month	
Virginia	21/admission [20]			
Washington	1/day [21]	2/month [21]	1/day	
West Virginia		1/30 days [22]		
Wisconsin		1/month [23]		
Wyoming		1/month [24]		

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[1] Alabama: Twelve noninpatient physician visits per calendar year in any combination of office visits, nursing home visits, or hospital outpatient visits.

[2] Arkansas: Eighteen noninpatient visits per fiscal year in any combination of office visits, home visits, long term care facilities visits, and outpatient hospital visits. Physician consultations are limited to two per recipient per fiscal year if provided in a physician's office, patient's home, or hospital.

[3] Florida: One inpatient hospital physician visit per day, with the exception of emergencies. One office visit per month is allowed for the supervision of chronic illness.

[4] Georgia: Twelve visits per year in any combination of office visits and/or nursing home visits.

[5] Hawaii: Two LTCF visits per month, with the exception of acute episodes with prior authorization.

[6] Kansas: Absolute limit of 12 office visits per year for adults. For EPSDT recipients, six office visits per calendar quarter (24 per year). Also, one routine LTCF visit per month (absolute). Confirmatory consultation limits: inpatient—one every ten days per provider per patient; noninpatient—one every 60 days per provider per patient. Exceptions are allowed with documentation of medical necessity.

[7] Kentucky: One comprehensive office visit per 12-month period, per patient, per physician.

[8] Louisiana: Eight noninpatient visits per year include physician office visits, home visits, long term care facility visits, visits to domiciliary-type institutions, well-care children visits, ophthalmological office visits, and emergency room visits. Exception when extension is medically approved to sustain life or in a medical emergency.

[9] Mississippi: An exception to the one-inpatient-visit-per-day limit is made for intensive or coronary care units, for which two visits per day are allowed. Twelve allowed noninpatient visits per fiscal year consist of combined total of physician office visits and rural health clinics visits.

[10] Missouri: Skilled nursing facilities excluded.

[11] Nevada: Limit of two visits per month in any combination of office or nursing facility visits; prior authorization required for additional visits.

[12] New Hampshire: Limit of twelve inpatient hospital procedure (not visits) per year. Exceptions include lab, x-ray, anesthesia, and assistance at surgery. Also, limit of eighteen physician services per fiscal year in any setting other than inpatient hospital. Exception: EPSDT.

[13] North Carolina: The limit of 24 "ambulatory medical visits" per year includes physician office visits, hospital outpatient (emergency rooms excluded) visits, freestanding clinic visits, podiatric visits, optometric visits, and chiropractic visits. Exempt are EPSDT; pregnancy related services; treatment for life-threatening conditions such as hemophilia, unstable diabetes, and cancer therapy; and terminal stages of life-threatening conditions such as ESRD. The State covers one adult health screening (preventive) exam per year for adults 21 years and over.

[14] North Dakota: More than one LTCF visit per month is allowed if it is medically necessary.

[15] Ohio: Twelve LTCF visits allowed per year, unless additional visits would prevent a condition leading to more costly care. The limit of four visits per provider per month encompasses physician home visits, office visits, inpatient hospital visits, and visits to outpatient hospital facilities. Prior authorization is required for additional visits, up to a maximum of ten per month, with the exception of inpatient hospital visits. Prior authorization is not required for up to ten inpatient visits.

[16] Oklahoma: The limit of four visits per month includes physician office visits, home visits, organized outpatient hospital clinic visits, and any other physician visits, except those to nursing homes and inpatient hospital patients. (This includes psychiatrists.) Exceptions include treatment for acute physical injury, family planning, or EPSDT.

[17] Pennsylvania: INPATIENT: $1,000 is the maximum amount paid per hospitalization for physician services. Also, two inpatient consultations per specialty per hospitalization. OUTPATIENT: $500 per day on all noninpatient physician services. BOTH: Payment limited to one visit per provider per day for hospital, home, office, emergency room, clinic, inpatient care, nursing home, and screening visits.

[18] South Carolina: The absolute 18-visits-per-year limit encompasses almost all ambulatory care: physician office, outpatient departments, speech and hearing, podiatric, dental, chiropractic, vision care. Exceptions include: patients with cancer, on dialysis with allergies, on insulin, or utilizing psychiatric services.

[19] Vermont: One physician visit per day for acute hospital care. One visit per week for SNFs; one visit per calendar month for ICFs. Additional visits must be adequately substantiated.

[20] Virginia: Absolute limit of 21 visits per hospital admission. (Allowed hospital days limited to 21 per 60-day period for same diagnosis.)

[21] Washington: Exception to the limit of one inpatient hospital visit per day: those surgeries that are reimbursed with a global fee that includes follow up visits. Exception to the limit of two long term care facility (LTCF) visits per month: additional visits that are justified by diagnosis.

[22] West Virginia: Exception to the limit of one LTCF visit per 30 days: documented acute condition.

[23] Wisconsin: Limit of one routine LTCF visit per month.

[24] Wyoming: One routine LTCF visit per month.

Source: National Governors' Association. State Medicaid Program Information Center: 1986. A Catalogue of State Medicaid Program Changes, p. 2.

As of December 1986, 12 States also had implemented mandatory second surgical opinion programs. (See table III–5). Under these programs, the need for certain specified procedures or groups of procedures must be confirmed in advance by another physician before payment will be made.

Table III–5.—SECOND SURGICAL OPINION PROGRAMS, BY STATE, DECEMBER 1986

States	Mandatory program	Procedures covered
Colorado	X	20
Indiana	X	20 groupings
Massachusetts	[1] X	10
Michigan	X	[2] 17
Minnesota	[3] X	4
Missouri	X	Approx. 100
New Jersey	X	6
Oregon	X	121
South Carolina	([4])	
Tennessee	X	5
Virginia	X	10 groupings
Washington	X	4
Wisconsin	[5] X	9 groupings

[1] Massachusetts Mandatory second surgical opinion programs do not apply if Medicaid is second payor. Also, the State standardized to a hands-on review model for second opinions. Paper reviews are not accepted.

[2] Michigan Second surgical opinions are required only for certain of the diagnosis codes for each surgery.

[3] Minnesota For inpatient services only; second surgical opinion is not required for day surgery.

[4] South Carolina Preadmission certification is required for six specific procedures. If certification is denied, the recipient may obtain a second opinion. When the second opinion agrees with the first, the procedure is allowed.

[5] Wisconsin Exceptions to the requirement of a second opinion are made for emergencies and situations where the procedure is incidental to major surgery.

Source: National Governor's Association. State Medicaid Program Information Center: 1986. A Catalogue of State Medicaid Program Changes. p. 2.

C. SNF AND ICF SERVICES

Federal Medicaid rules require that a physician must make a medical evaluation of each applicant's need for skilled nursing facility care and certify the need for these services. Similarly a physician must certify the need for ICF services. In addition, an interdisciplinary team of health professionals must make a comprehensive evaluation of the need for care in an ICF. The State agency is required to evaluate each applicant's need for admission by reviewing and assessing the required evaluation.

A number of States have instituted formal preadmission screening programs. These programs apply to persons already eligible for Medicaid. In some States they also are applied to private patients expected to become eligible for Medicaid in the near future. Thirty States had instituted such programs as of Fall 1985. (See table III–6).

Table III–6.—CHARACTERISTICS OF STATE NURSING HOME PREADMISSION SCREENING PROGRAMS (FALL 1985)

State	Type of program		Required for Medicaid payment for			Applicabe to patients applying from	
	Statewide	Limited	Immediate Medicaid eligibles	Expected Medicaid eligibles	Conversion to Medicaid from private	Home or community	Hospital
Arkansas		X	X		(3)	(3)	
California		X				X	X
Colorado	X		X	All <300% SSI	X	X	X
Connecticut		X					X
Delaware		X	X	Elig "soon"		X	X
District of Columbia	X		X				X
Florida		X	X		X	X	X
Georgia	X		X	Elig< 180 days	X	X	X
Idaho	X		X		X	X	X
Illinois	X		X	Elig< 60 days		X	X
Indiana	X		X	All private		X	X
Iowa	X		X		X	X	X
Kansas	X		X			X	
Maine	X		X			X	
Massachusetts	X		X		(3)	(3)	
Minnesota	X		X	Elig<180 days		X	X
Missouri	X		X			X	X
Montana	X		X		(3)	(3)	
Nevada	X		X	Elig<180 days	X	X	X
New Hampshire	(1)						
New Jersey	X		X	(2)	X	X	
New York		X	X			X	X
North Dakota	X		X			X	X
Ohio		X	X		X	X	X
Oregon	X		X	All <300% SSI	(3)	(3)	
Pennsylvania		X	X		X	X	X
Rhode Island	X		X		(3)	(3)	
South Carolina	X		X		X	X	X
Virginia	X		X	Elig<180 days		X	X
Washington	X		X			X	X
Wisconsin		X	X		X	X	X

[1] New Hampshire reported that the State initiated a PAS program in 1986. PAS is mandatory for all current Medicaid eligible and those expected to become eligible within 180 days, as well as private-pay patients converting to Medicaid. It is in effect statewide and affects patients applying to nursing homes form hospitals or their own homes.

[2] InterStudy reported that New Jersey's PAS program applied on a mandatory basis to all private pay-patients. However, the State Medicaid agency says that the program currently does not apply to private patients.

[3] Not reported.

Source: U.S Library of Congress. Congressional Research Service. Medicaid Eligibility for the Elderly in Need of Long-term Care. CRS Report for Congress No. 87–986 EPW, prepared under contract by Edward Neuschler, Center for Health Policy Studies, National Governors' Association. Washington, 1987. p. 28. Abstracted from: Iversen, Laura Himes. A Description and Analysis of State Pre-Admission Screening Programs. Excelsior, MN, InterStudy, March 1986.

D. OTHER SERVICES

States may impose utilization controls or limits on other service categories. Many States place limitations on prescription drug coverage. They may limit the quantity of drugs dispensed by limiting the number of prescriptions that can be filled or refilled in a certain time period or limiting the quantity per prescription (for example, to a 30 day supply). They may restrict (or not cover at all) over-the-counter drugs. They may also establish a restrictive formulary which only permits payment for a limited list of drugs unless an exception is granted.

States may also impose a number of additional types of limits on covered services. The most frequent control across service categories is that of prior authorization. Prior authorization involves approval, in advance of service delivery, of a particular service, procedure, or equipment based on a finding of medical necessity. States may also exclude or limit coverage of specified procedures or services within a service category and may limit the number of times a procedure may be provided in a given period.

V. EXPERIMENTAL ITEMS/TRANSPLANTS

Public health programs and private health insurance plans generally decide whether or not to reimburse for a particular medical procedure based on whether it is safe and effective. Generally, they will pay for items that are classified as accepted medical practice, but not for those classified as "experimental" or "investigational." The Federal Medicare program, whose reimbursement decisions often guide other insurance or medical program payers, precludes payment for experimental items.

Individual States can make their own decisions with respect to coverage of transplants under Medicaid, provided certain requirements are met. Federal law prohibits Federal matching for organ transplant procedures unless: (1) the State plan provides written standards for coverage; and (2) the standards provide that similarly situated individuals are treated alike and any restrictions placed on providers who could provide the care are consistent with access to high quality care. If a State covers organ transplants, such services must be sufficient in amount, duration, and scope to achieve their purpose.[20]

A 1986 telephone survey of the States by HCFA showed that all States, except Wyoming, have paid for some transplants. Table III–7 shows, by State, coverage policy with respect to specific categories of organ transplants.

Table III–7.—COVERAGE OF ORGAN TRANSPLANTS, BY PROCEDURE, BY STATE, 1986

Stateg	Heart	Heart/lung	liver	Bone marrow	Pancreas	Kidney
Alabama			X	X		X
Alaska						X
Arizona	X		X	X		X
Arkansas						X
California	X		X	X		X
Colorado	X	X	X	X		X
Connecticut	X	X	X	X		X
Delaware	X		X	X		X
District of Columbia	X		X	X		X
Florida				X		X
Georgia			X	X		X

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[20] Despite these requirements, courts may require States to fund transplants in individual cases. For example, in *Velia Montoya* v. *W. Johnston* (DC WD Tex 1987) 654 F. Supp. 511, the district court enjoined the State from enforcing a payment limit which had the effect of excluding medically necessary liver transplants for two children.

Table III–7.—COVERAGE OF ORGAN TRANSPLANTS, BY PROCEDURE, BY STATE, 1986—Continued

Stateg	Heart	Heart/lung	liver	Bone marrow	Pancreas	Kidney
Hawaii				X		X
Idaho				X		X
Illinois	X	X	X		X	
Indiana	X		X	X		X
Iowa	X		X	X	X	X
Kansas				X		X
Kentucky	X		X	X		X
Louisiana	X	X	X	X		X
Maine	X		X	X		X
Maryland	X	X	X	X		X
Massachusetts	X	X	X	X		X
Michigan	X	X	X	X	X	X
Minnesota	X	X	X	X	X	X
Mississippi				X		X
Missouri	X		X	X		X
Montana	X		X	X		X
Nebraska	X		X	X		X
Nevada			X	X		X
New Hampshire			X	X		X
New Jersey	X		X	X		X
New Mexico	X	X	X	X		X
New York	X	X	X	X		X
North Carolina	X	X	X	X		X
North Dakota	X	X	X	X	X	X
Ohio	X	X	X	X	X	X
Oklahoma			X	X		X
Oregon	X	X	X	X		X
Pennsylvania	X	X	X	X	X	X
Rhode Island			X	X		X
South Carolina			X	X		X
South Dakota				X		X
Tennessee	X		X	X		X
Texas	X		X	X		X
Utah			X	X		X
Vermont	X			X		X
Virginia			X			X
Washington	X		X	X		X
West Virginia	X		X	X		X
Wisconsin	X		X	X	X	X
Wyoming						
Totals	33	15	41	46	8	49

Source: U.S. Department of Health and Human Services, Health Care Financing Administration. Office of Reimbursements Policy, Division of Dialysis and Transplant Payment Policy. Medicaid Coverage and Payment Policies for Organ Transplants: A Fifty State Review [by Sandy Zachary], undated.

VI. COST SHARING

States are permitted to impose cost-sharing charges with certain major exceptions. These cost-sharing charges may serve as a means of utilization control.

States may not impose deductible or coinsurance charges on either the categorically needy or the medically needy under the following circumstances:

—No such charges may be imposed on services provided to children under age 18; States may provide that no copayments will be imposed for children aged 18 to 21;

—States are barred from imposing copayments on services related to pregnancy (including prenatal, delivery, and post-partum services) or to any other medical condition which may complicate the pregnancy. States may provide that no copayments will be imposed for any services provided to pregnant women;

—States may not impose copayments on services provided to inpatients in hospitals, SNFs, ICFs, or other medical institution if such individuals are required to spend all their income for medical expenses except for the amount exempted for personal needs;

—States may not impose copayments on emergency, family planning, or hospice services; and

—States are precluded from imposing copayments on categorically needy enrollees in HMOs. They may also exempt the medically needy from such charges.

States may impose charges on restricted groups under a waiver, but only if the waiver is for a demonstration project that the Secretary finds meets certain conditions (including testing a unique and previously untested use of copayments).

Cost sharing charges must be "nominal" in amount as defined under regulations. In the case of noninstitutional services, the maximum deductible cannot exceed $2.00 per month; coinsurance charges may range from $0.50 to $3.00 (depending on the amount Medicaid pays for the service). In the case of institutional services, the maximum charge per admission cannot exceed 50 percent of the payment the program makes for the first day of care.

The Secretary may waive the nominality requirement in the case of nonemergency services in emergency rooms where the State has established, to the satisfaction of the Secretary, that alternative sources of nonemergency services are actually available and accessible. When the Secretary is satisfied that such conditions have been met and a waiver has been granted, the State may impose a charge up to twice the amount defined as nominal.

States may also impose an enrollment fee, premium, or similar charge on the medically needy though States generally have not availed themselves of this option.

No provider participating under Medicaid may deny services to an individual because of his inability to pay cost-sharing charges; however, this does not exclude the beneficiary from liability for paying such charges.

As of March 1986, 24 States imposed cost-sharing charges on one or more Medicaid services. (See table III–8.) The service category for which cost sharing charges were imposed most frequently was drugs.

Table III–8.—STATE COPAYMENT POLICIES IN EFFECT AS OF MARCH 31, 1986

State	Service *	Co-pay amount	Applicable to *
Alabama	Drugs	Varies	Age 18+; pregnant women
	Physician office visits (including optometric)	$1.00	
Alaska	None		
Arkansas	None		
California	Drugs	$1.00	Age 12+ (waiver)
	Outpatient hospital	$1.00	
	Emergency room (inappropriate use)	$5.00	
Colorado	None		
Connecticut	None		
Delaware	None		
District of Columbia	Drugs	$0.50	Age 21+; pregnant women
	Eyeglasses	$2.00	
Florida	Dentures	5% coins	Age 21+; pregnant women
	Prosthetic devices		
	—hearing aids	5% coins	
Georgia	None		
Hawaii	None		
Idaho	None		
Illinois	Inpatient hospital	Varies [1]	
Indiana	None		
Iowa	Dental	$3.00	Age 21+
	Prosthetic devices		
	—hearing aids	$3.00	
	—orthopedic shoes	$2.00	
	Drugs	$1.00	
	Optometrist	$2.00	
	Podiatrist	$1.00	
	Chiropractor	$1.00	
	Other practitioner		
	—psychologist	$2.00	
	Medical equipment and supplies	$2.00	
	Eyeglasses		
	—optician services	$2.00	
	Rehabilitation agency	$2.00	
	Transportation		
	—ambulance	$2.00	
Kansas	Chiropractor	$1.00	Age 18+
	Dental	$1.00	
	Drugs	$1.00	
	Other practitioner		
	—psychologist	$1.00	
	Optometrist	$1.00	
	Transportation		
	—Nonemergency ambulance	$1.00	
	Physician office visit	$1.00	
	Hospital (inpatient)	$25.00	
	Hospital (outpatient)	$10.00	
	Freestanding psychiatric (non-State) hospital per admission	$25.00	
	Ambulatory surgery Center Services	$10.00	
Kentucky	None		
Louisiana	None		
Maine	Drugs	$0.50	Children in psychiatric facilities or programs
Maryland	None		
Massachusetts	None		
Michigan	Dental	$3.00	Age 21+; pregnant women
	Drugs	$0.50	Except institutionalized
	Optometrist	$2.00	
	Podiatrist	$2.00	

Table III–8.—STATE COPAYMENT POLICIES IN EFFECT AS OF MARCH 31, 1986—Continued

State	Service *	Co-pay amount	Applicable to *
	Chiropractor	$1.00	
	Prosthetic devices		
	—hearing aids	$3.00	
Minnesota	None		
Mississippi	Hospital (inpatient)	$5.00	Age 18+
	Hospital (emergency room)	$2.00	
	Drugs	$1.00	
	Transportation		
	—ambulance	$2.00	
	Optometrist	$2.00	
	Dental	$2.00	
	Home health visit	$2.00	
	Rural health		
	(Office visits)	$1.00	
	Physician (office visits)	$1.00	
Missouri	Speech, hearing, language		
	—audiology	Varies [2]	Age 18+; pregnant women
	Dental	Varies [2]	
	Dentures	5% coins	
	Optometrist	Varies [2]	
	Podiatrist	Varies [2]	
	Inpatient hospital	$10.00	
	Outpatient	$3.00	
	Drugs	Varies [3]	
Montana	Drugs	$0.50	Age 21+
	Inpatient hospital	$3.00	
	Outpatient hospital	$1.00	
	Physical therapy	$0.50	
	Occupational therapy	$0.50	
	Podiatry	$1.00	
	Speech, hearing, language		
	—Speech therapy	$0.50	
	—Audiology	$0.50	
	Prosthetic devices		
	—Hearing aids	$0.50	
	—Medical equipment and supplies	Varies [2]	
	Home Health	$1.00	
	Home dialysis for ESRD	$0.50	
	Private duty nursing	$0.50	
	Clinic services	$1.00	
	Psychological	$0.50	
	Dental	$1.00	
	Optometrist	$1.00	
	Eyeglasses	$1.00	
	Physicians	$1.00	
Nebraska	None		
Nevada	Chiropractor	$1.00	Age 19+
	Clinic		
	—mental health	$1.00	
	Dental	$2.00	
	Dentures	$3.00	
	Drugs	$1.00	
	Eyeglasses	$3.00	
	Inpatient mental		
	Disease Age 65+	50% 1st day	
	SNF's under 21	50% 1st day	
	PT, OT, Speech/hearing	$1.00	
	Podiatrist	$1.00	
	Prosthetic devices	$3.00	
	Transportation		
	—ambulance	$3.00	

Table III–8.—STATE COPAYMENT POLICIES IN EFFECT AS OF MARCH 31, 1986—Continued

State	Service *	Co-pay amount	Applicable to *
	—taxi	$1.00	
	—medivan	$2.00	
	ICF's	50% 1st day	
	ICF's–MR	50% 1st day	
New Hampshire	Drugs	$0.75	
New Jersey	None		
New Mexico	None		
New York	None		
North Carolina	Chiropractor	$0.50	Pregnant women
	Clinic	$0.50	
	Dental	$2.00	
	Drugs	$0.50	
	Eyeglasses		
	—Each pair and repair of $5+	$2.00	
	Optometrist	$1.00	
	Outpatient hospital	$1.00	
	Physician	$1.00	
	Podiatrist	$2.00	
	Rehabilitative		
	—Nonhospital Dialysis	$2.00	
North Dakota	Eyeglasses		
	—replacement lenses and frames within 1 yr of original RX	$3.00	
Ohio	None		
Oklahoma	None		
Oregon	None		
Pennsylvania	Pharmacy	$0.50	
	Psychiatric	$0.50	
	Radiology, nuclear medicine, diagnostic	$1.00	
Rhode Island	None		
South Carolina	Dental-per procedure	$1.00	Age 21+; pregnant women
	Drugs	$0.50	
	Optometrist	$1.00	
	Podiatrist	$1.00	
South Dakota	Drugs	$1.00	Pregnant women
	Outpatient hospital	5% coins	
	Physician	$3.00	
	Dental	$1.00	
	Dentures	$3.00	
	Prosthetic		
	—DME	5% coins	
	EPSDT	$1.00	
	Mental Health Centers	5% coins	
	Chiropractors	$0.50	
Tennessee	None		
Texas	None		
Utah	Outpatient hospital		
	—unnecessary emergency room	$3.00	
Vermont	Drugs	$1.00	
Virginia	Optometrist		
	—Eye exams	$1.00	Age 21+; pregnant women
	Clinic	$1.00	
	Drugs	Varies [4]	
	Inpatient	$30.00	
	Outpatient		
	—nonemergency	$2.00	
	Physician	$1.00	
Washington	None		
West Virginia	Drugs	Varies [4]	

Table III–8.—STATE COPAYMENT POLICIES IN EFFECT AS OF MARCH 31, 1986—Continued

State	Service *	Co-pay amount	Applicable to *
Wisconsin	Inpatient hospital		
	—mental diseases	$75/stay	Pregnant women
	Durable medical equipment	$1.00	
	Optometrist	Varies [2]	
	Chiropractor		
	—per procedure	$0.50	
	Dental	Varies [6]	
	Physical and occupational therapy/ per 15 minutes	$0.50	
	Speech/hearing/language	Varies [7]	
	Drugs	$0.50	
	Prosthetic devices	Varies [2]	
	—Hearing aids		
	Eyeglasses	Varies [2]	
	Transportation	Varies [8]	
	Orthodontist	Varies [5]	
	Day treatment service	$.50/day	
	Prosthodontic appliance	$3.00	
	Oral surgery	$1.00	
	Adjunctive service	$1.00	
	Outpatient hospital	$2.00	
	Optometric services	Varies [2]	
	Inpatient hospital		
	—General hospital	$75/stay	
Wyoming	None		

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[1] $2.00 for pier diem of $275 to $325; $3.00 for per diem over $325.
[2] $.50 to $3.00.
[3] $.50 to $2.00.
[4] $.50 on $10.00 or less; $1.00 on $10.01 and over.
[5] $2.00 to $3.00.
[6] $.50 to $1.00.
[7] $.50 per 15 minutes for some services; $1.00 per procedure for others.
[8] $1.00 to $2.00.

* These columns refer to specific groups of people for whom States have opted to impose charges through provisions of law.
Source: U.S. Department of Health and Human Services: Health Care Financing Administration Analysis of State Medicaid Program characteristics, 1986. Aug. 1987. p. 75–79.

CHAPTER IV. REIMBURSEMENT [1]

SUMMARY

Under Medicaid law, States now have considerable freedom to develop their own methods and standards for reimbursement of Medicaid services. This chapter reviews States' methods for determining provider payment and for collecting amounts due from other potential sources of payment for Medicaid beneficiaries.

Before 1980, Medicaid programs were required to use the same methods as Medicare in paying for hospital and nursing home services. Facilities were paid on the basis of the actual costs they incurred in providing care. Legislative changes in 1980 and 1981 permitted States to develop their own reimbursement methodologies for these services. Most States have now moved to "prospective" payment systems, under which the amount of payment for a defined unit of service (such as a day of care in a nursing home or full treatment of an inpatient hospital case) is established in advance. Some of these systems are comparable to Medicare's prospective payment system (PPS), under which reimbursement varies according to the classification of each case into a diagnosis related group, or DRG. In other States, hospitals are paid a flat rate, for each day of care or for total care for each patient, without regard to diagnosis. Finally, States may develop rates through negotiation with hospitals. In a number of States, the Medicaid program participates in an "all-payor" system, under which most insurers in the State agree to a single method for paying hospitals. States are required to make additional payment to "disproportionate share" hospitals, those that serve a higher than average number of Medicaid and other low-income patients.

For nursing home services, current Medicaid law distinguishes between two types of facilities: skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). The distinction between the two types of care will be eliminated effective October 1, 1990. Most States use a single method for reimbursing SNFs, ICFs, and a third type of facility, intermediate care facilities for the mentally retarded (ICFs/MR). Nearly all States have adopted prospective payment systems for SNF services, ICF services, or both. However, eight States have continued to use cost reimbursement for ICFs/MR.

Some States use uniform rates. There may be one statewide rate for SNFs and another for ICFs, or there may be a more elaborate rate schedule, distinguishing among facilities by location, bed size, or ownership. Most of the remaining States set daily rates on an individual facility basis. Generally, the State uses the facility's costs as a base, but reduces the rates if they exceed cost ceilings established by comparing a facility's costs to those of similar facilities. Six States have adopted "case mix" reimbursement systems, under which higher payments are made to facilities that accept more severely ill patients.

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[1] Mark Merlis is the author of this chapter.

For services of physicians or other individual practitioners, payment amounts are usually the lesser of the provider's actual charge for the service or a maximum allowable charge established by the State. Payments may be determined through "prevailing charge" screens, under which the maximum is set at a fixed percentile of the customary charges of area providers for comparable services. Or the State may use a fee schedule, specifying a flat maximum payment amount for each service.

States use a wide variety of methods for reimbursing hospital outpatient services. Hospitals may be paid their actual costs for providing outpatient care, or the State may pay fixed rates. These may be based on a hospital's historic costs or may involve a fee schedule comparable to those used for physician services.

For prescription drugs, States are required to establish a system that pays a pharmacy's cost for acquiring a drug plus a fixed dispensing fee. Payment for drugs that exist in both brand-name and generic versions is limited to the price of the least expensive readily available generic equivalent. The pharmacy has an incentive to substitute the generic drug unless the physician specifically requests that the brand-name version be furnished.

Although Medicaid programs cover numerous other kinds of services, the law establishes specific payment rules for only a few of them. Payment to rural health clinics, hospices, and clinical laboratories must generally follow Medicare rules. For some services, including laboratory services, durable medical equipment, and eyeglasses, States are permitted to establish "volume purchasing" programs, selecting a sole source for the service through competitive bidding or other means.

Medicaid is the payer of last resort, secondary to any other insurance coverage a beneficiary may have or to any other third party who may be liable for medical payments or medical support on the beneficiary's behalf.

An estimated 3.7 million Medicaid beneficiaries were also eligible for Medicare benefits in fiscal year 1986. Nearly all States have "buy-in" agreements with Department of Health and Human Services (DHHS) for these dual eligibles. The State pays Medicare premiums on the beneficiaries' behalf. Medicare pays for the services it covers, with Medicaid paying beneficiary cost-sharing, the deductibles and coinsurance required under Medicare. Medicaid also generally pays for services that Medicare does not cover but that are included in the State's Medicaid plan, such as prescription drugs and most nursing home care. Provisions of the Medicare Catastrophic Coverage Act of 1988 will require all States to buy in for most aged and disabled Medicare beneficiaries with incomes below 100 percent of the poverty line.

Some Medicaid beneficiaries may also have private health insurance, or may be eligible for payments through automobile or liability insurance or workers' compensation. Finally, an absent parent may be responsible for medical support payments. Applicants for Medicaid benefits are required to disclose any potential payment sources, and Medicaid programs must have a system for pursuing third party claims. For most services, States have adopted a "cost avoidance" system, denying payment of claims for which third party liability is known to exist. For a few types of services, Medicaid programs pay the claims and then seek to collect from the responsible party.

I. INTRODUCTION

Under Medicaid law, States have considerable freedom to develop their own methods and standards for reimbursement of Medicaid services. Only three basic statutory requirements apply to all types of services. First, providers must accept Medicaid reimbursement as payment in full, except for any beneficiary cost-sharing amounts provided for by the State plan or any amount due from a medically needy beneficiary with a spend-down liability (see chapters II and III for a discussion of these provisions). Second, Medicaid is secondary to any other health coverage or third party payment source available to beneficiaries, including Medicare. Third, "methods and procedures" for making payments must be such as to assure that payments will be "consistent with efficiency, economy, and quality of care." [2] One other general rule has been established by regulation: the State's payment rates must be sufficient to attract enough providers so that covered services will be as available to Medicaid beneficiaries as they are to the general population.

Specific payment rules or methodologies are prescribed by law for only a few types of providers: rural health clinics, independent laboratories, and hospices. General guidelines are provided for payment to hospitals, nursing homes, and health maintenance organizations (HMOs) or comparable organizations (see chapter V for a discussion of HMO reimbursement). However, Federal Medicaid regulations go beyond the statute in establishing payment ceilings or other tests of the reasonableness of State reimbursement methodologies for services not specifically covered by the statute.

Part II of this chapter describes the legal requirements governing Medicaid reimbursement for specific types of providers or services and provides an overview of the variety of payment methodologies adopted by States within the context of those requirements. Except as otherwise noted, the basic information on individual States' reimbursement systems is derived from a CRS analysis of several different reference sources. The sources are discussed in a note at the conclusion of this chapter. This chapter does not include information on the specific payment rates established by States for different services. Information on actual payment rates for physician, hospital, and nursing home services may be found in appendix G.

Part III discusses the coordination of Medicaid payments with other payments that may be available for services furnished to Medicaid beneficiaries, including Medicare and other insurance plans. The discussion concludes with an explanation of the relationship between Medicaid and the Indian Health Service.

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[2] The Health Care Financing Administration relies on this provision as a general authority to regulate State reimbursement methodologies and to establish upper limits for State payments.

II. MEDICAID REIMBURSEMENT METHODOLOGIES

A. Inpatient Care

For inpatient services, including those of hospitals, SNFs, and ICFs, two basic payment methodologies are in use: retrospective and prospective.

In a retrospective system, payment amounts are determined after services are rendered and are based on the actual costs incurred by the provider in furnishing those services. Commonly the State will make periodic interim payments, with final reimbursement amounts determined after an annual audit.[3] The costs ultimately reimbursed may be limited to "reasonable" costs, as defined by the State. States may establish ceilings, above which a provider's costs will not be considered reasonable.

In a fully prospective system, payment amounts are determined in advance. The provider receives a specified rate for each service rendered, regardless of whether the provider's actual costs are more or less than that rate. Until 1980, State Medicaid programs were required to follow Medicare reimbursement principles in paying for inpatient services. Under the Medicare rules in effect at that time, this meant that nearly every State used a retrospective reasonable cost system (a few States had waivers to operate "all-payor" hospital systems; see section b (1), below). The Omnibus Reconciliation Act of 1980 (ORA80, Public Law 96-499) repealed this requirement for nursing home services, freeing States to establish new methodologies of their own. The Omnibus Budget Reconciliation Act of 1981 (OBRA81, Public Law 97-35) did the same for inpatient hospital services.

The law now provides simply that payment rates for hospitals and nursing homes must be "reasonable and adequate" to meet the costs of "efficiently and economically operated" facilities in providing care that meets Federal and State quality and safety standards. For hospital inpatient care the rates must also be sufficient to assure reasonable access to services and must include adjustments for hospitals serving a high proportion of low-income patients; payments may not exceed the hospital's customary charges to the public.[4] For both kinds of facilities there are also limits on State reimbursement for costs relating to transfer of the facility to new ownership.

Many States have responded to the new flexibility by shifting from retrospective to prospective payment systems for both hospital and nursing home services. States' interest in prospective payment has stemmed from concerns that providers paid on a full cost basis have no incentive to perform efficiently and may furnish unnecessary services. Critics of prospective payment systems contend that quality may be compromised if providers are forced to provide care within a fixed budget, and that providers may refuse care to patients whose costs are likely to exceed the predetermined payment.

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[3] The Omnibus Budget Reconciliation Act of 1987 (OBRA87, Public Law 100-203) repealed a requirement that State audits be coordinated with audits of the same providers conducted by Medicare.

[4] In the case of a public hospital that provides free care or imposes only nominal charges, Medicaid reimbursement is not limited by this "customary charge" rule. The State may provide reasonable compensation for services to Medicaid beneficiaries.

1. INPATIENT HOSPITAL SERVICES

Medicaid regulations provide that the aggregate amount spent by a State for inpatient services during a year may not exceed the aggregate amount which would have been spent if the State had used the current Medicare system.[5] Beginning in 1983, Medicare shifted to a prospective payment system (PPS) for inpatient services. This has altered the benchmark against which a State's Medicaid reimbursement system is measured, but has not changed the basic rule.[6]

a. Basic Systems. As of August 1987, only 7 States and the District of Columbia continued to use a retrospective cost-based system for inpatient hospital services, while 42 States had adopted some form of prospective system. Table IV–1 shows the basic system in use in each State. It should be noted that the systems described in the table and in the following discussion are those used for most hospitals in the State. States may use different modes of payment for particular classes of facilities. For example, States may follow Medicare in using a prospective payment system for acute general hospitals and a reasonable cost system for psychiatric and other specialized hospitals.

Table IV–1.—HOSPITAL INPATIENT REIMBURSEMENT METHODOLOGIES, FISCAL YEAR 1987

State	Basic method	Remarks [1]
Alabama	Prospective	Class ceilings
Alaska	Prospective	Budgeted
Arkansas	Prospective	([2])
California	Prospective	Selective contracting
Colorado	Prospective	DRG
Connecticut	Prospective	All-payer (excl. Medicare)
Delaware	Cost	Medicare pre-1983 method
District of Columbia	Cost	Statewide cap on total reimbursement
Florida	Prospective	County ceilings
Georgia	Prospective	([2])
Hawaii	Prospective	Class ceilings
Idaho	Cost	Inflation ceiling
Illinois	Prospective	Selective contracting
Indiana	Cost	([2])
Iowa	Prospective	DRG
Kansas	Prospective	Budgeted
Kentucky	Prospective	Class ceilings
Louisiana	Prospective	Per case target rates
Maine	Prospective	All payer (excl. Medicare)
Maryland	Prospective	Budgeted, all-payer (incl. Medicare)

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[5] Note that this requirement applies only in the aggregate. Reimbursement for specific facilities or patients may exceed Medicare levels, so long as overall average reimbursement for the State does not.

[6] In the 1987 budget reconciliation legislation, H.R. 3545, the House voted to prohibit the Secretary from capping Medicaid inpatient expenditures at the Medicare level. However, the final conference agreement on OBRA of 1987 (Public Law 100–203) did not include this provision.

Table IV–1.—HOSPITAL INPATIENT REIMBURSEMENT METHODOLOGIES, FISCAL YEAR 1987—Continued

State	Basic method	Remarks [1]
Massachusetts	Prospective	Budgeted, all-payer (excl. Medicare)
Michigan	Prospective	DRG
Minnesota	Prospective	DRG
Mississippi	Prospective	Class ceilings
Missouri	Prospective	([2])
Montana	Prospective	DRG
Nebraska	Prospective	([2])
Nevada	Prospective	Class rates by admission, added payment for stay >15 days
New Hampshire	Cost	([2])
New Jersey	Prospective	DRG, all-payer (incl. Medicare)
New Mexico	Prospective	Class ceilings
New York	Prospective	Various ceilings, all-payer (excl. Medicare)
North Carolina	Prospective	Reduced rates after annual day limits for high cost hospitals
North Dakota	Cost	Medicare pre-1983 method
Ohio	Prospective	DRG
Oklahoma	Prospective	Retrospective case mix adjustment
Oregon	Prospective	DRG
Pennsylvania	Prospective	DRG
Rhode Island	Prospective	Inflation ceilings by class
South Carolina	Prospective	DRG
South Dakota	Prospective	DRG
Tennessee	Prospective	([2])
Texas	Prospective	DRG
Utah	Prospective	DRG
Vermont	Prospective	Negotiated rates
Virginia	Prospective	Class ceilings
Washington	Prospective	DRG
West Virginia	Cost	Medicare pre-1983 method
Wisconsin	Prospective	([2])
Wyoming	Cost	Medicare pre-1983 method

[1] See text for discussion of terminology.
[2] Further system details not available.

Source: Congressional Research Service analysis. See Note at end of chapter for details of sources.

Of the 42 States using prospective payment for inpatient hospital services in August 1987, 14 had adopted a system comparable to Medicare's prospective payment system (PPS), under which reimbursement varies according to the classification of each case into a diagnosis related group, or DRG. The remaining States' systems are of three basic kinds. In 21 States, hospitals are paid a flat rate, based on historic cost and utilization, for each day of care or for total care for each patient, without regard to diagnosis.[7] In four States, rates are budgeted, based on assumptions about the costs and utilization for each hospital in the *current* year. Finally, three States develop rates through a process of negotiation with hospitals. Two of these States, California and Illinois, use selective contracting systems, choosing preferred hospital providers through a process of competitive negotiation.

Diagnosis Related Group (DRG) Systems. Under a DRG system, the reimbursement rate for services to a particular patient is based on the patient's diagnosis and/or the nature of the services furnished. Each case is classified into one of a set of diagnosis related groups (the Medicare system uses 473 DRGs, but some States use fewer in their Medicaid systems). Each DRG is assigned a weighting factor, which measures the relative resources required by a typical patient with a particular problem or complaint, as compared to all other patients. Under Medicare, the factors range from a low of 0.1 for false labor to a high of 11.9 for certain respiratory problems; an average case has a DRG weight of 1.0. A single all-inclusive payment is made for each case in a particular DRG, by multiplying a fixed predetermined rate by the weighting factor for the applicable DRG. (Medicare's system makes a number of additional adjustments in the payment for certain hospitals.)

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[7] In a few of these systems, rates varied by service (obstetrical, medical, surgical, pediatric, intensive care) rather than by diagnosis.

In Medicaid DRG systems, the rates may vary by hospital, or there may be different rates for specified classes of facilities, defined by size, geographic area, or other factors. The State's system may allow additional reimbursement for "outliers," patients whose costs or length of inpatient stay are significantly higher than the average for other patients in the same DRG. (Special outlier payment adjustments for infants in certain hospitals will be required beginning in 1989; see section b, below.)

Because Medicaid patients may tend to enter the hospital for different reasons than Medicare patients, the weighting factors established for DRGs under Medicare may not be appropriate for Medicaid reimbursement. (Medicare weights may be especially inappropriate for pediatric cases, because of the very small number of children receiving Medicare benefits.) Most States using DRGs have developed their own weights on the basis of Medicaid-specific data; some have used Medicare weights temporarily while collecting their own data.

Flat Rate Systems. In a typical flat rate system, the payment rate for each hospital is equal to that hospital's average costs, per day or per case, in a base year, plus some allowance for inflation. Many States using this approach have imposed "ceilings," under which the costs used for developing an individual hospital's rate may not exceed a fixed percentile of the costs for other comparable hospitals. The peer group to which the hospital is compared may be based on class (bed size, teaching/nonteaching) or on location. Some States, instead of applying ceilings to base year costs, use class ceilings in computing their inflation adjustments. The hospital's annual increase in costs may not exceed that of typical hospitals in its peer group. One State, New York, uses a complex system which includes class and area ceilings along with ceilings based on case mix, i.e., the relative severity of the patients treated by each hospital (New York was in transition to a DRG system in late 1987).[8]

If the State sets flat rates per case, rather than per day, the hospital may be overpaid or underpaid if the average length of the hospital stay for each case is significantly different from that in the base year. A number of States have provided for some form of adjustment in these situations. In Nevada, for example, the basic per-case rate for each patient is expected to cover the first 15 days of care. The hospital may receive additional daily payment for days beyond that limit.

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[8] Intergovernmental Health Policy Project. George Washington University. Major Changes in State Medicaid and Indigent Care Programs: Jan.-Aug. 1987. Washington. 1987. p. 8.

Budgeted Systems. Alaska, Kansas, Maryland, and Massachusetts use budgeted reimbursement systems, under which the rates paid to hospitals are based on projections of probable utilization and hospital revenue requirements. In Kansas, hospitals are paid on a premium basis, rather than for each patient seen. The State predicts in advance for each hospital the total number of Medicaid days to be used and the total allowable cost for those days; the hospital then receives periodic lump sum payments. The total amount payable to the hospital is adjusted only if the number of days used is significantly different from the original estimate.

In the other three States, the budgeting process is used to develop a per diem payment rate for each hospital. Rate adjustments may be required if the hospital's cost or revenue experience differs significantly from the estimates used in budgeting.

Negotiated Systems. California, Illinois, and Vermont develop rates through negotiation with participating hospitals. California and Illinois have developed selective contracting systems, using an option established by OBRA81. Section 2175 of the Act allowed States to apply for waivers of Medicaid requirements, including the requirement that beneficiaries be allowed a free choice of medical providers, in order to allow the development of innovative delivery or reimbursement systems (the waiver rules are discussed more fully in chapter V). One of the available options for States is to limit program participation (except for emergency services) to providers who meet reimbursement, quality, and utilization standards approved by the State. California and Illinois have used this authority to restrict the inpatient hospitals from which beneficiaries may obtain services (Kentucky also received a waiver for this purpose in 1984, but terminated its project shortly thereafter). Except in emergencies or other exceptional cases, beneficiaries may use only those hospitals selected for participation through a system of competitive negotiation. Reimbursement rates for the participating hospitals are established in the course of the negotiation. In Illinois' system, the State and the hospital also project the total number of days of care to be used by Medicaid patients. Reimbursement rates are reduced for days in excess of the projected limits. Although Vermont negotiates rates, it does not restrict program participation to a limited number of hospitals.

b. Special Payment Issues—All-payor Systems. Beginning in the 1970's, several States established "all-payor" hospital rate-setting systems. In these systems, all insurers or other payors in the State, including Medicare and Medicaid, agreed to pay uniform rates or use a standard reimbursement methodology for inpatient services. Medicare and Medicaid involvement in an all-payor system was permitted only on a demonstration basis, through waivers approved by the Secretary under his general authority to conduct tests of program improvements. The original all-payor States thus served as proving grounds for alternatives to the traditional Medicare/Medicaid reasonable cost system.

Two of these original systems, Maryland's and Massachusetts', were budget based. New Jersey's was the first to experiment with

DRGs and served as a forerunner for the current Medicare prospective payment system (PPS) for inpatient hospital services. New York set all-inclusive rates for each hospital on a per day basis, using historic cost and a variety of ceilings based on peer group comparisons.

Since the enactment of Medicare's PPS in 1983, continued participation of Medicare in an all-payor system has depended on a showing by the State that costs under its system were rising no faster than they would if the State had conformed to the Medicare PPS rules. Only two States, New Jersey and Maryland, continue to operate full all-payor systems. Several others maintain partial all-payor systems, including Medicaid and private insurers but excluding Medicare. These State systems include Connecticut, Maine, Massachusetts, and New York. A Medicaid program may continue to participate in such a system so long as it complies with the general rules governing Medicaid reimbursement, including the Secretary's regulatory requirement that aggregate Medicaid reimbursement not exceed Medicare levels.

Disproportionate Share Hospitals. OBRA81 required that States' Medicaid reimbursement systems "take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs." Plans in some States to meet this requirement by making additional payments to disproportionate share hospitals potentially conflicted with the Secretary's regulation capping aggregate Medicaid reimbursement at Medicare levels. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, Public Law 99-272) prohibited the Secretary from limiting States' payment adjustments to disproportionate share hospitals.

Prior to 1987, States were free to establish their own criteria for classifying facilities as disproportionate share hospitals and to develop their own reimbursement methods for these hospitals. OBRA87 (Public Law 100-203, as modified by Public Law 100-360) has established minimum criteria which all States' systems must meet beginning in July 1, 1988. A hospital will be eligible for additional payment if (a) its Medicaid utilization rate is more than one standard deviation above the mean Medicaid utilization rate for all Medicaid-participating hospitals in the State, or (b) its low-income utilization rate is at least 25 percent.[9] In addition to meeting one of these two tests, the hospital must have on staff at least two obstetricians who are prepared to accept Medicaid patients. This requirement does not apply to children's hospitals or to those that do not furnish nonemergency obstetrical care.

In computing the amount of the supplementary payment, the State must either (a) use the formula for comparable payment adjustments under Medicare, with special adjustments for children's hospitals, or (b) provide for a fixed payment increase or percentage increase for disproportionate share hospitals plus an additional increase for hospitals whose Medicaid utilization is more than one standard deviation above the statewide mean. The payment adjustments are required even if they result in Medicaid payments to a hospital in excess of the hospital's usual charges to the public for similar services.

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[9] The Medicaid utilization rate is defined as the number of days of care furnished to Medicaid beneficiaries during a given period divided by the total number of days of care provided during the period. The low-income utilization rate is the sum of two fractions: Medicaid payments plus State and local subsidies divided by total patient care revenues, and inpatient charges attributable to charity care (other than charity care subsidized by State or local government) divided by total inpatient charges.

The new requirements will be phased in over a 3 year period ending in fiscal year 1990. Certain alternative State systems for compensating disproportionate share hospitals are temporarily or permanently exempt from the requirements, provided that the aggregate increased payments under those systems are equal to the aggregate amounts that would be paid if the States complied with the requirements. However, no State may be exempted under a section 2175 waiver for selective contracting.

Public Law 100-360 further requires that States modify certain reimbursement practices for inpatient services provided by designated disproportionate share hospitals to infants under one year old. Effective July 1, 1989, reimbursement for such services must be made without regard to any durational limits in the State Medicaid plan (such as a provision that the State covers only a certain number of days of care per admission or per year). In States that pay hospitals on a prospective basis, the payment systems must provide for "outlier" adjustments, to compensate disproportionate share hospitals for infants whose hospital stays are unusually long or costly.

Administrative Days/Swing Beds. Under Medicare, small rural hospitals may enter into "swing bed" agreements with Health Care Financing Administration (HCFA), under which beds may be used either for inpatient hospital care or for care equivalent in intensity to that furnished by a nursing home. Costs are allocated and reimbursement adjusted to reflect the level of care furnished to each patient. A Medicaid program may also allow for swing beds, but only in hospitals which have entered into a Medicare swing bed arrangement. The State may develop a specific payment methodology for swing bed days of care at the nursing home level or may pay at a rate based on average payments for comparable services in freestanding nursing homes. The swing bed program assists hospitals that are underused and also helps to meet local shortages of nursing home beds.

Sometimes a hospital which is not a swing bed facility will provide care to a patient at the nursing home level of intensity because a place cannot be found for the patient in an appropriate facility and the patient cannot be discharged. (See appendix G for a discussion of nursing home placement problems.) The days of inpatient care received by patients in this situation are known as "administrative days." Medicaid payment for an administrative day is limited by statute to the statewide average Medicaid payment rate for a day of care in a skilled nursing facility.

2. NURSING FACILITY SERVICES

Currently, Medicaid law distinguishes between two kinds of nursing homes, SNFs and ICFs. Services in SNFs are also covered by Medicare; the less intensive services provided by ICFs are not covered by Medicare but are covered under Medicaid in every State except Arizona (none of the territories cover ICF services). States may also cover services in intermediate care facilities for the mentally retarded (ICFs/MR). These are covered in every State except Arizona and Wyoming.

For Medicaid SNF services, as for inpatient hospital services, regulations provide that aggregate payments may not exceed what would have been paid under Medicare rules. Because Medicare does not cover ICF services, no equivalent rule could be applied to ICF reimbursement. However, the statute has required that there be a "reasonable cost differential" between the State's average payment for a day of SNF care and the average payment for a day of ICF care. The differential is "reasonable" if it is comparable to that prevailing in other States.

OBRA87 eliminates the payment differential requirement, effective October 1, 1990. Beginning on that date, the Medicaid law will cease to distinguish between SNFs and ICFs (ICFs/MR will remain a distinct category). This change is part of a broader set of nursing home reforms included in the Act, which will provide stricter and more uniform standards for nursing facilities participating in Medicare and Medicaid. In addition to eliminating the SNF/ICF payment differential, the Act provides that States must adjust Medicaid payment rates to allow for the costs that will be incurred by facilities in meeting the new standards. (Facilities granted waivers of some of the standards may face a downward adjustment.) The adjustments must be reflected in the State plan by April 1, 1990. The following description of Medicaid reimbursement for SNFs and ICFs is based on the systems presently in effect.

a. Basic Methods. Table IV–2 shows the basic nursing home reimbursement methodologies used by State Medicaid programs in fiscal year 1987. In 36 States and the District of Columbia, a single method was used for SNFs, ICFs, and ICFs/MR. Multiple methods are shown on the table only when a State distinguishes among these types of facilities. The basic payment methods for ICFs/MR are the same as those for ordinary ICFs unless otherwise indicated.

Table IV–2.—NURSING FACILITY REIMBURSEMENT METHODOLOGIES, FISCAL YEAR 1987

State	Basic method	Remarks [1]
Alabama	Prospective	Class ceilings
Alaska	Prospective	Budgeted
Arkansas:		
SNF/ICF	Prospective	Class rates
ICF/MR	Cost	([2])
California	Prospective	Area-class rates
Colorado	Prospective	Class ceilings, shared savings
Connecticut	Prospective	Class ceilings, shared savings, case mix
Delaware:		
private	Prospective	([2])
public	Cost	Class ceilings

Table IV–2.—NURSING FACILITY REIMBURSEMENT METHODOLOGIES, FISCAL YEAR 1987—Continued

State	Basic method	Remarks [1]
District of Columbia	Prospective	(2)
Florida:		
SNF/ICF	Prospective	Class rates
ICF/MR	Cost	(2)
Georgia	Prospective	(2)
Hawaii	Prospective	Shared savings
Idaho	Cost	Class ceilings, shared savings
Illinois	Prospective	Class rates, case mix
Indiana	Prospective	Area-class rates, shared savings
Iowa	Prospective	Level of care ceilings (except for ICF/MR), shared savings
Kansas	Prospective	(2)
Kentucky	Prospective	Class, cost center ceilings, shared savings
Louisiana:		
SNF/ICF	Prospective	Statewide rates by level of care
ICF/MR	Prospective	Individual facility rates
Maine:		
SNF	Cost	(2)
ICF	Prospective	Class ceilings, shared savings
Maryland	Prospective	Class ceilings, case mix, shared savings
Massachusetts	Prospective	Budgeted
Michigan:		
SNF/ICF	Prospective	(2)
ICF/MR	Cost	(2)
Minnesota	Prospective	Area ceilings, case mix, shared savings
Mississippi	Prospective	Class ceilings, shared savings
Missouri	Prospective	Class ceilings
Montana:		
SNF/ICF	Prospective	(2)
ICF/MR	Cost	Inflation ceilings
Nebraska	Prospective	Shared savings, case mix
Nevada:		
SNF/ICF	Prospective	Cost center ceilings
ICF/MR	Cost	(2)
New Hampshire:		
SNF	Cost	(2)
ICF	Prospective	Class ceilings, shared savings
New Jersey:		
SNF/ICF	Prospective	Cost center ceilings
ICF/MR	Cost	(2)
New Mexico	Prospective	Class ceilings, shared savings
New York	Prospective	Class-area ceilings, case mix
North Carolina	Prospective	Cost center ceilings
North Dakota	Prospective	(2)
Ohio	Cost	Cost center ceilings, case mix
Oklahoma	Prospective	Statewide class rates
Oregon	Cost	Class ceilings
Pennsylvania	Cost	Class-area ceilings (except public ICF/MR)
Rhode Island	Prospective	Class-cost center ceilings, shared savings
South Carolina	Prospective	Class ceilings, shared savings
South Dakota	Prospective	Class ceilings
Tennessee:		
SNF	Cost	Fixed maximum per diem
ICF	Cost	Class ceilings
Texas	Prospective	Class rates
Utah:		
SNF/ICF	Prospective	Level of care rates
ICF/MR	Cost	Public facilities only
Vermont	Prospective	Class ceiling on rate of increase

Table IV–2.—NURSING FACILITY REIMBURSEMENT METHODOLOGIES, FISCAL YEAR 1987—Continued

State	Basic method	Remarks [1]
Virginia:		
SNF/ICF	Prospective	Class-area ceilings
ICF/MR	Cost	([2])
Washington	Prospective	Cost center ceilings, shared savings
West Virginia	Prospective	Class and case mix ceilings, shared savings
Wisconsin	Prospective	Class and cost center ceilings
Wyoming	Prospective	Statewide ceiling, shared savings

[1] See text for discussion of terminology.
[2] Further system details not available.
Source: Congressional Research Service analysis. See note at end of chapter.

As with hospital services, nursing home reimbursement may be either retrospective or prospective. Only four States continue to reimburse both SNFs and ICFs solely on a retrospective reasonable cost basis. The rest have adopted prospective payment systems for SNF services, ICF services, or both. However, eight States have continued to use cost reimbursement for ICFs/MR.[10]

Of those paying prospectively, nine States use uniform rates. There may be one statewide rate for SNFs and another for ICFs, or there may be a more elaborate rate schedule, distinguishing among facilities by location, bed size, or ownership. Two other States have budgeted rate systems comparable to those for hospital services.

Most of the remaining States have developed nursing home payment systems which resemble the typical inpatient hospital payment systems. The State uses the individual facility's historic cost as a base, updates the cost with an inflation factor to establish a daily rate, and then reduces the rate if it exceeds one or more cost ceilings. (Some States which pay on a retrospective cost basis also use cost ceilings.) Ceilings may be based on a percentile of costs for a class of facilities, grouped by county, bed size, or ownership. Another approach is to use cost center ceilings. The costs of providing care are split into a number of components: administration, nursing, food, and so on. A separate cap is applied to each of these cost centers.

Cost ceilings may function implicitly as penalties for low occupancy. If a facility has the same fixed costs as others in its class but fewer patients, its per capita cost will exceed ceilings based on the average per capita cost for the class. Several States have built explicit occupancy assumptions into their ceilings, limiting payment for any facility which fails to achieve 85 percent occupancy.

Class averages may be used for other policy purposes as well. A number of States will share with a facility any difference between its actual costs and the ceiling for its class, as an incentive for efficiency. Another requires facilities whose nonadministrative labor costs are below the median for their class to increase their staffing or wage levels until the costs reach the median.

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[10] For ICF/MR services, the distinction between prospective and cost systems may not always be meaningful. Prospective rates may be set at a level sufficient to meet the facilities' full anticipated costs. Most ICF/MR services are furnished in State facilities. If the State's Medicaid reimbursement to these facilities is less than their full operating cost, the State will have achieved Medicaid savings only at the expense of another part of the State budget.

States may also modify rates directly to achieve policy goals. Illinois has developed a Quality Incentive Program (QUIP), which provides bonus payments to facilities meeting standards beyond the minimum. Some States have established disproportionate share adjustments, comparable to those for hospitals, to compensate facilities with a high number of Medicaid patients. At least one provides bonuses for facilities which accept high-cost cases directly from hospitals. North Dakota offers additional reimbursement to facilities that agree to set their private rates equal to their Medicaid rate (see appendix G for a discussion of public-private rate equalization as a means of combatting discrimination in admissions).

b. Case Mix Adjustments. Some States have found that the overall distinction between SNF and ICF levels of care may not adequately reflect the full variation in cost and intensity of services required by different patients. Within the ICF level, for example, a bed-bound patient may require considerably more attention than an ambulatory one. If a State pays the same amount for both kinds of cases, facilities may have a financial incentive to refuse admission to "heavy care" patients. As a result, seven States have adopted case mix payment methodologies, under which reimbursement is partially dependent on the kinds of patients the nursing home accepts. The States using case mix systems are Connecticut, Illinois, Maryland, Minnesota, Nebraska, New York (in part of the State), and Ohio. Other States are working to develop these systems, including Massachusetts, which has been granted waivers of Medicaid requirements for a case mix demonstration project. One State, West Virginia, has a system in which the payment ceilings, the limits above which a facility's costs will not be reimbursed, are based on case mix.

In a case mix system, the State establishes classes of patients, according to their diagnosis, degree of disability, or service requirements, and sets different standard payment rates or payment adjustment factors for each class. The State may use a simple range, perhaps from "light care" to "heavy care." New York has experimented with 16 resource utilization groups (RUGs), which attempt to classify nursing home patients by expected cost in the same way that DRGs classify hospital inpatients.

Some States that have not developed full-fledged case mix systems have still gone beyond the basic SNF/ICF distinction by establishing multiple classes of facilities, such as ICF–I, ICF–II, ICF–III. The difference between this approach and a case mix system is that case mix relies on direct assessment (and periodic reassessment) of each patient within a facility, rather than on assessment of the facility as a whole.

A State may also provide enhanced reimbursement for specific types of services needed by certain patients. A bedridden patient may require periodic turning and repositioning to avoid bedsores; another patient may need tube feeding. The State may add a fixed amount to the standard daily rate for each day that a patient requires these services, or it may take the need for such services into account in measuring case mix.

c. Reserved Beds. Nursing home patients will sometimes be away from the facility for a brief period, for a short-stay hospitalization or perhaps for a family visit. Where occupancy rates are high, the facility could conceivably admit another patient in this interval, leaving the absent patient unable to return. States may pay for leave days in order to ensure that a bed is reserved during a patient's absence. Rates may be reduced for these days, and a State may limit the number of reserve bed days it will pay in a year, either per patient or per facility.

B. PHYSICIAN AND OUTPATIENT CARE

1. PHYSICIAN SERVICES

For services of physicians or other individual practitioners, Medicaid payment amounts are usually the lesser of the provider's actual charge for the service or a maximum allowable charge established by the State. Table IV-3 shows the general approach used by each State in establishing maximum payments for physician services. Two basic methods are in use: prevailing charge screens and fee schedules or relative value scales.

Table IV-3.—METHODS OF ESTABLISHING MAXIMUM PHYSICIAN RATES

State	Method [1]
Alabama	Prevailing charges
Alaska	Prevailing charges
Arkansas	Fee schedule
California	Relative value scale
Colorado	Relative value scale
Connecticut	Fee schedule
Delaware	Fee sechedule
District of Columbia	Fee schedule
Florida	Fee schedule
Georgia	Fee schedule
Hawaii	Prevailing charges
Idaho	Relative value scale
Illinois	Fee schedule
Indiana	Prevailing charges
Iowa	Prevailing charges
Kansas	Prevailing charges
Kentucky	Prevailing charges
Louisiana	Prevailing charges
Maine	Fee schedule
Maryland	Fee schedule
Massachusetts	Fee schedule
Michigan	Fee schedule
Minnesota	Prevailing charges
Mississippi	Fee schedule
Missouri	Fee schedule
Montana	Fee schedule
Nebraska	Prevailing charges
Nevada	Fee schedule
New Hampshire	Fee schedule
New Jersey	Fee schedule
New Mexico	Prevailing charges
New York	Fee schedule
North Carolina	Prevailing charges
North Dakota	Prevailing charges
Ohio	Fee schedule
Oklahoma	Prevailing charges

Table IV–3.—METHODS OF ESTABLISHING MAXIMUM PHYSICIAN RATES—Continued

State	Method [1]
Oregon	Fee schedule
Pennsylvania	Fee schedule
Rhode Island	Fee schedule
South Carolina	Relative value scale
South Dakota	Prevailing charges
Tennessee	Prevailing charges
Texas	Prevailing charges
Utah	Fee schedule
Vermont	Fee schedule
Virginia	Fee schedule
Washington	Fee schedule
West Virginia	Fee schedule
Wisconsin	Prevailing charges
Wyoming	Prevailing charges

[1] See text for discussion of terminology.

Source: Congressional Research Service analysis. See Note at end of chapter for details of sources.

Prevailing charge screens. In 19 States, maximum physician payments are determined through methods comparable to those used by Medicare in establishing reasonable charges for physician services. The Medicare reasonable charge for a specific service to a specific patient is the lowest of (a) the provider's actual charge for that service; (b) the provider's customary charge for comparable services; or (c) the "prevailing" charge in the area for comparable services. For Medicare, the prevailing charge for an area is set at the 75th percentile of the customary charges established for all the providers in the area (because of rate of increase limits and other rules, the Medicare prevailing charge is in fact frequently lower than the 75th percentile). Some Medicaid systems use a different percentile, while others have dropped the prevailing charge "screen" and use the individual provider's customary charge as the maximum. In establishing customary or prevailing charges, States may use information developed by other payors, such as Medicare or Blue Shield, or may compile their own data.

Fee Schedules and Relative Value Scales. Thirty States and the District of Columbia have developed fixed fee schedules, specifying a flat maximum payment amount for each type of service; the maximum may be unrelated to actual provider charges. Most Medicaid programs develop these schedules on their own; four States have used relative value scales (RVS), usually developed by an outside organization. In a relative value scale, each type of service is given a specific weight. A brief physician office visit might have a value of 3, an appendectomy a value of 150. The State then multiplies the different values by a single standard dollar amount. If a unit is valued at $5, the State will pay $15 for the brief office visit and $450 for the appendectomy. The effect is the same as under a fee schedule, except that the Medicaid agency has an external reference for its pricing decisions. Several standard RVS systems are available for States which choose this approach; the most familiar is the California Relative Value Studies for physician, laboratory, and x-ray services. Similar scales exist for other provider types, such as the Nevada scales for dental and ocular services.

A number of States have modified their physician reimbursement systems in order to encourage participation or increase access to care. Of particular concern in recent years has been access to obstetrical services. Several States have increased rates for maternity care faster than the rates for other services.[11] States have also provided enhanced reimbursement for primary care physicians and for ambulatory surgery.

2. HOSPITAL OUTPATIENT SERVICES

Medicaid regulations provide that payment for services in hospital outpatient departments or clinics may not exceed the amount that would have been paid for the same services if provided to a Medicare beneficiary (including Medicare's payment plus any beneficiary cost-sharing amounts). Medicare's payments for outpatient services, unlike those for most inpatient care, continue to be made on a reasonable cost basis.

Table IV-4 shows each State's basic Medicaid reimbursement methodology for outpatient hospital services.

Table IV-4.—HOSPITAL OUTPATIENT REIMBURSEMENT METHODOLOGIES, FISCAL YEAR 1987

State	Basic methods [1]
Alabama	Fee schedule
Alaska	Prospective payment
Arkansas	Fee schedule
California	Negotiated rate or fee schedule
Colorado	Percent of cost or charges
Connecticut	Prospective, not more than 116 percent of physician rate for comparable service
Delaware	Reasonable cost
District of Columbia	Prospective
Florida	Prospective, county ceilings
Georgia	Cost/charge ratio
Hawaii	Negotiated
Idaho	Reasonable cost
Illinois	Fee schedule
Indiana	Reasonable cost
Iowa	Reasonable cost
Kansas	Fee schedule
Kentucky	Percent of charges
Louisiana	Reasonable cost
Maine	Reasonable cost
Maryland	Prospective, budgeted (all-payer including Medicare)
Massachusetts	Prospective (all-payer excluding Medicare)
Michigan	Prevailing costs
Minnesota	Prevailing charges
Mississippi	Reasonable cost
Missouri	Percent of cost or charges
Montana	Reasonable cost
Nebraska	Prevailing charges
Nevada	Physician fee schedule
New Hampshire	Reasonable cost
New Jersey	Cost/charge ratio
New Mexico	Reasonable cost
New York	Fee schedule

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[11] Five States did so in the first 8 months of 1987: Florida, Mississippi, New Mexico, Rhode Island, and West Virginia. Intergovernmental Health Policy Project, 1987, p. 9.

Table IV-4.—HOSPITAL OUTPATIENT REIMBURSEMENT METHODOLOGIES, FISCAL YEAR 1987—Continued

State	Basic methods [1]
North Carolina	Percent of cost
North Dakota	Reasonable cost
Ohio	Reasonable cost
Oklahoma	Fixed percent of inpatient per diem rate
Oregon	Percent of allowable cost
Pennsylvania	Fee schedule
Rhode Island	Prospective, inflation ceilings by class
South Carolina	Percent of allowable cost
South Dakota	Reasonable cost
Tennessee	Reasonable cost
Texas	Reasonable cost
Utah	Percent of charges
Vermont	Reasonable cost
Virginia	Reasonable cost
Washington	Prospective (fee schedule for lab, x-ray)
West Virginia	Fee schedule
Wisconsin	Prospective
Wyoming	Reasonable cost

[1] See text for discussion of terminology.

Source: Congressional Research Service analysis. See note at end of chapter for details of sources.

Twenty-three States use approaches similar to the Medicare system, reimbursing on a retrospective cost basis. Some of these States use cost ceilings, limiting annual increases to a fixed indexed amount or limiting allowable costs for specific types of services. Five of the States using cost methods take a percentage discount from allowable costs.

Eight States and the District of Columbia have developed some form of prospective payment system; another eight have developed a fee schedule comparable to those used for physician services. Two States have negotiated rates. The remaining eight States use a variety of methods, including prevailing charge or cost screens (three States), rates based on the historic ratio of costs to charges (two States), and a fixed percent of charges (two States). Finally, Oklahoma sets the rate for an outpatient visit at a fixed percentage of the daily rate for inpatient care at the same facility.

Partly because of problems in obtaining access to physicians' services, many Medicaid beneficiaries have relied on hospital outpatient department and emergency rooms as a primary source of care (see appendix G for a discussion of this problem). The cost for outpatient services may be considerably higher than the cost of identical services furnished in a physicians' office. Several States have reduced outpatient reimbursement to reflect the actual level of services provided. For example, Connecticut limits payments for outpatient services to a fixed percentage of the allowable physician payment for the same service. Other States pay reduced rates to emergency rooms for treatment of nonemergency cases.

C. Prescription Drugs

Medicaid regulations establish aggregate limits on payments for prescription drugs. Two separate limits are used, one for certain multiple source drugs—those for which therapeutic equivalents or "generic" versions are available from more than one manufacturer—and one for all other drugs.

For each multiple source drug, HCFA establishes a price limit equal to 150 percent of the estimated wholesale cost of the least expensive therapeutic equivalent.[12] The State's total payments for all such drugs during a given period may not exceed what would have been spent if the State had paid the price limits plus a reasonable dispensing fee. (The State may pay more for any particular drug so long as the total for all drugs does not exceed the aggregate limit.) The effect of this requirement is that, when a lower-cost "generic" equivalent exists for a brand-name drug, a pharmacy will be paid the generic price even if the brand-name drug is actually furnished. The pharmacy therefore has a financial incentive to substitute the generic equivalent for the brand-name drug. If the prescribing physician specifies that generic substitution is unacceptable (for example, by writing "dispense as written" or "no substitution" on the prescription), the HCFA price limits do not apply. The pharmacy must supply the brand-name drug and may be paid the full brand-name cost.

For all other drugs (including multiple source drugs for which the prescribing physician has requested no substitution), aggregate statewide payments may not exceed the lesser of (a) the pharmacies' usual and customary charge to the general public and (b) the estimated acquisition (wholesale) cost of ingredients plus a reasonable dispensing fee. Again, this limit applies in the aggregate and not to each individual prescription. For most drugs, the ingredient cost is limited to the State's best estimate of what providers generally are paying for a drug. At least one State uses different estimates according to the size of the provider, on the assumption that high-volume pharmacies pay lower wholesale prices. Other States follow the same principle in establishing the dispensing fee. Several States will pay no dispensing fee at all for drugs furnished directly by a physician.

Some States have taken additional steps to encourage generic substitution. The State may establish its own price limits at levels below those set by the HCFA, or may develop limits for multiple-source drugs not yet considered by HCFA. Of the 48 States covering prescription drugs in fiscal year 1987, 32 had established their own limits for at least some drugs.[13] When no limit exists for a multiple-source drug, the State may offer pharmacies a bonus payment if they practice generic substitution. Finally, at least two States will not accept the simple certification of a physician that the brand-name drug is necessary, but require the physician to obtain prior authorization before the State will pay the full brand-name price.

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[12] The current price limit system took effect October 29, 1987. It replaced an earlier system under which prices for multiple source drugs were limited to maximum allowable costs (MACs) established by a pharmaceutical reimbursement board within DHHS. The major differences between the new upper limits and the MACs are that the new limits are established by HCFA, are based on specific price references, and apply only if all the formulations of a drug approved by the Food and Drug Administration have been determined to be therapeutically equivalent.

[13] National Pharmaceutical Council. Pharmaceutical Benefits Under State Medical Assistance Programs. Reston, Va. 1987. p. 74

D. OTHER SERVICES

The services described above account for over 88 percent of total Medicaid expenditures; remaining expenditures are distributed among a wide variety of providers and service types. The following discussion is limited to services for which special payment rules are established by Federal law.

1. RURAL HEALTH CLINICS

Payment to rural health clinics, as defined by Medicare, must follow Medicare rules or, for Medicaid-covered services not covered under Medicare, the State's payment rules for comparable services. Medicare payment to a freestanding rural health clinic is at a fixed comprehensive rate for each patient visit. For a rural health clinic which is operated as part of a hospital, skilled nursing facility, or home health agency, Medicare payment follows the reasonable cost principles applicable to the parent facility.

2. LABORATORIES

Payment for a laboratory test performed by a physician, independent laboratory, or hospital (except tests for the hospital's own patients) may not exceed the amount that would be paid under Medicare rules for the same test. For tests furnished on or before December 31, 1989, Medicare payment is based on regional fee schedules established by the Secretary; after that date a national fee schedule will be used for most laboratory services.

3. HOSPICE CARE

If the State elects to cover hospice services, it must follow Medicare reimbursement rules for hospices. Under Medicare rules, payment for each day of care furnished by the hospice is at fixed rates according to the nature of the care received by the patient: a day may be classed as routine home care, continuous home care, inpatient respite care, or general inpatient care. Average payments per patient are subject to an annual "cap amount" updated annually by the Secretary and applied on an aggregate basis. The aggregate number of inpatient care days provided by the hospice in any 12 month period may not exceed 20 percent of the total number of days of hospice care provided. OBRA87 provides that Medicaid inpatient days furnished to patients with acquired immunodeficiency syndrome (AIDS) are not counted towards this limit. Under Medicaid, additional payment for room and board may be made for patients who receive hospice services while residing in a skilled nursing or intermediate care facility (this is not true under Medicare).

E. VOLUME PURCHASING

States may arrange for "volume purchasing" of laboratory services (other than those provided by hospitals or rural health clinics) or medical devices, such as durable medical equipment or eyeglasses. One or more providers of the specified service may be selected by the State, through competitive bidding or other means, as the sole source of the items covered in an area or statewide. Some

States will permit other providers to furnish the item or service, but only if they are prepared to meet the price of the approved source. The State must ensure that services remain accessible to beneficiaries. If the arrangement is for laboratory services, the laboratory must be State-licensed and/or meet other requirements established by the Secretary.

As of December 1987, the following 16 States had some form of volume purchasing arrangement for optical services: Alabama, Arkansas, Florida, Georgia, Illinois, Maine, Massachusetts, Michigan, Minnesota, North Carolina, Ohio, Oregon, South Carolina, Vermont, Washington, and Wisconsin. Five States used volume purchasing for hearing aids: Alaska, Florida, Minnesota, South Carolina, and Texas. Minnesota and Washington have sole source contracts for oxygen; Minnesota also has a sole source for wheelchairs. Only Nevada has used volume purchasing for laboratory services.[14]

III. COORDINATION WITH OTHER PAYMENT SOURCES

Medicaid is the payor of last resort, secondary to any other insurance coverage a beneficiary may have or to any other third party who may be liable for medical payments or medical support on the beneficiary's behalf. In terms of dollar impact, the most important source of third party coverage for Medicaid beneficiaries is Medicare. Some beneficiaries may receive private health insurance through an employer or may be covered under the policy of another family member. Other possible sources of third party payment include automobile or other liability insurance or workers' compensation. Finally, an absent parent may be responsible for medical support payments.

A. Medicare

While coverage under Medicare Part A (hospital insurance) is automatic for persons meeting eligibility standards, coverage under Part B (supplemental medical insurance) requires payment of a monthly premium by the beneficiary. Some persons not automatically eligible for Part A coverage may also obtain that coverage by paying a premium.[15] In addition, Medicare beneficiaries are liable for cost-sharing, deductible and coinsurance payments for Medicare-covered services.

A State may enter into an agreement with the Secretary under which Medicaid pays the Medicare Part B premium on behalf of Medicaid beneficiaries eligible for Part A coverage. (For certain beneficiaries eligible for Part A coverage only if they pay the Part A premium, Medicaid may pay this as well.) This arrangement is known as "buy-in." If a State pays the premium on behalf of a beneficiary, Medicare is responsible for payment for that beneficiary's services under its usual coverage and reimbursement rules. The Medicaid program then pays required beneficiary cost-sharing amounts.

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[14] State Medicaid Program Information Center, National Governors' Association. A Catalogue of State Medicaid Program Changes. Washington. 1986. p. 67–8.

[15] Medicare Part A, Hospital Insurance, covers inpatient hospital and skilled nursing facility care, hospice services, and some home health care. Part B, Supplemental Medical Insurance, includes physician, hospital outpatient, home health care, and a variety of ancillary services.

1. ELIGIBILITY FOR BUY-IN COVERAGE

Approximately 3.7 million Medicaid beneficiaries were also covered by Medicare in fiscal year 1986. This included 3.1 million beneficiaries aged 65 and older and an estimated 20 percent of the 3.2 million beneficiaries who qualified for Medicaid as a result of a disability.[16] These beneficiaries qualified for Medicaid under the usual eligibility rules as categorically needy or medically needy. Federal funding is available at the State's usual matching rate for Medicare premiums paid on behalf of categorically needy beneficiaries. The State may also buy in for medically needy beneficiaries, but must pay the entire premium with State funds.

Only one State and two territories, Wyoming, Puerto Rico, and the Northern Mariana Islands, have not entered into a buy-in agreement for the categorically needy. (Some States that buy in for the categorically needy exclude categorically needy beneficiaries who are also receiving Social Security or railroad retirement payments.) Of the 39 States and other jurisdictions with medically needy programs, 23 buy in for medically needy beneficiaries (see Table IV-5).

Table IV-5.—MEDICARE BUY-IN ARRANGEMENTS,[1] DECEMBER 1987

	State has Medically Needy program	State buys in for Medically Needy
Alabama		
Alaska		
American Samoa		
Arizona		
Arkansas	X	X
California	X	X
Colorado		
Connecticut	X	
Delaware		
District of Columbia	X	X
Florida	X	X
Georgia	X	X
Guam		
Hawaii	X	X
Idaho		
Illinois	X	
Indiana		
Iowa	X	X
Kansas	X	X
Kentucky	X	
Louisiana	X	
Maine	X	
Maryland	X	X
Massachusetts	X	X
Michigan	X	X
Minnesota	X	X
Mississippi		
Missouri		
Montana	X	X

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[16] The 20 percent estimate for the disabled group was supplied by Vivian Gornick, Office of Research and Demonstrations, HCFA.

Table IV-5.—MEDICARE BUY-IN ARRANGEMENTS,[1] DECEMBER 1987—Continued

	State has Medically Needy program	State buys in for Medically Needy
Nebraska	X	X
Nevada		
New Hampshire	X	
New Jersey	X	
New Mexico		
New York	X	X
North Carolina	X	X
North Dakota	X	
Northern Mariana Islands		
Ohio		
Oklahoma	X	
Oregon	X	X
Pennsylvania	X	
Puerto Rico		
Rhode Island	X	X
South Carolina		
South Dakota		
Tennessee	X	
Texas	X	X
Utah	X	X
Vermont	X	
Virgin Islands	X	X
Virginia	X	X
Washington	X	X
West Virginia	X	
Wisconsin	X	X

[1] All States except Wyoming have entered into a Medicare buy-in agreement for those individuals who are categorically needy. Only one of the territories, the Virgin Islands, has entered into a buy-in agreement.

Source: Compiled by Congressional Research Service from Commerce Clearing House. Medicare and Medicaid guide. [Chicago. Updated weekly.]

OBRA86 (Public Law 99-509) allowed States, at their option, to provide Medicaid to aged and disabled persons who did not meet usual Medicaid standards but who met a higher income standard established by the State, up to 100 percent of the Federal poverty level, and whose resources did not exceed the limits for SSI applicants. The State could provide this new group of beneficiaries with full Medicaid coverage, or it could choose to cover only the Medicare premiums and cost-sharing amounts.[17] For this group, the State may pay premiums for Part A coverage (for persons not automatically entitled to Part A), as well as the Part B premiums. Florida, New Jersey, and the District of Columbia have provided coverage to additional aged and disabled beneficiaries under the OBRA86 rules.

Under the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360), Medicaid coverage of low-income aged and disabled Medicare beneficiaries is mandatory rather than optional. All States and the District of Columbia will be required to pay Medicare premiums and cost-sharing for beneficiaries with incomes below 100 percent of the Federal poverty level; coverage of this group will remain optional for the territories.[18] In addition to covering Medicare cost-sharing amounts, States will be required to pay for prescription drugs for these beneficiaries up to the deductible limit established by the new Medicare catastrophic prescription drug benefit. (In States already furnishing prescription drugs under Medicaid, coverage for the new beneficiaries may conform to existing State policies.) The new requirements are being phased in over a period that ends January 1, 1992, or, for certain States, January 1, 1993. (See chapter II for a full discussion of the eligibility and transition rules.)

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[17] States may also choose to make monthly payments to health maintenance organizations (HMOs) or similar entities that have contracted with HCFA to provide services to Medicare beneficiaries.

The changes made by Public Law 100–360 supplement, but do not supersede previous rules for Medicaid coverage of the aged and disabled. Many persons will still qualify for Medicaid benefits under existing standards for the categorically or medically needy. At a State's option, a State may also continue to extend full Medicaid coverage to persons qualifying under the OBRA86 option, instead of just paying Medicare premiums and cost-sharing. After the transition period under Public Law 100–360, a State could have three distinct classes of aged and disabled individuals qualifying for assistance.

Although buy-in will be mandatory for the beneficiaries obtaining coverage under Public Law 100–360, it remains optional for beneficiaries whose incomes exceed the poverty level but who qualify for benefits under standard Medicaid rules (chiefly persons in institutions). A State could choose not to pay the Medicare premiums for those beneficiaries and instead provide the usual benefits available under the State's Medicaid plan. However, States are given a financial incentive to obtain Part B coverage for all Medicaid beneficiaries who could qualify for it. If the State fails to buy in for a beneficiary and therefore covers as Medicaid, services that could have been covered by Medicare, it may not claim Federal matching for the resulting expenditures. (There is an exception for services furnished prior to the date of the beneficiary's Medicaid application and covered as a result of a retroactive grant of Medicaid eligibility).

2. COVERAGE AND PAYMENT RULES UNDER BUY-IN

In addition to having the Medicare premiums and cost-sharing amounts paid on their behalf, persons qualifying for Medicaid under existing standards may obtain services which are included in the State plan for Medicaid but which are not covered by Medicare, such as prescription drugs, dental care, or nursing home care beyond the very limited Medicare coverage. In some States, on the other hand, the Medicaid plan may not include all the services covered by Medicare. For example, the State might not cover heart transplants, which Medicare now covers. In this circumstance, the State may pay the Medicare deductible or coinsurance for those services, even though it would not pay for the service for other Medicaid beneficiaries.

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[18] Both the OBRA86 eligibles and those obtaining coverage under Public Law 100–360 are treated as categorically needy for the purpose of Federal funding. That is, Federal funding is available at the State's usual matching rate for Medicaid premiums paid on behalf of these persons.

Some States which use fee schedules to limit practitioner reimbursement may pay less than the full cost-sharing amount on Medicare claims. If, for example, the Medicare allowable charge for a particular service is $100, Medicare pays $80, leaving $20 to be paid as coinsurance. If the State's fee limit for the same service is $75, the State may conclude that the practitioner has already been paid in full. Other States will pay the full cost-sharing amounts determined by Medicare so long as these amounts are not themselves in excess of the State's fee limits. If the State does not pay the full cost-sharing amounts, it must use a sliding income or income-resource scale to determine the amount it will pay. The State may pay the full cost-sharing amounts for persons covered under the OBRA86 option or under Public Law 100–360, even if it does not do so for other joint Medicare/Medicaid beneficiaries.

B. OTHER THIRD PARTY LIABILITY

Applicants for Medicaid are required to disclose any insurance coverage or other potential third party payment source at the time of application or redetermination, and must assign to the State any right of recovery they may have. The State is required to have a system for pursuing third party claims; this system must be integrated with the State's Medicaid Management Information System (MMIS; see chapter VI). States may act on the basis of the information furnished by beneficiaries or may identify potential payments by other means. For example, States must review cases of hospitalization resulting from accidental injury, on the possibility that a legal action is pending. States may also have agreements on data exchange with workers' compensation boards or State motor vehicle accident report files.

States must also have systems for collecting medical support payments from absent parents. Beneficiaries must cooperate in establishing paternity and obtaining medical support (this requirement may be waived for good cause, such as a possibility of reprisal). The Medicaid agency must have a cooperative agreement with the Title IV–D (child support enforcement) agency and other appropriate agencies. When subdivisions or other States assist in enforcement and collection action, the Medicaid agency must make an incentive payment to the other State or locality equal to 15 percent of the amount recovered; this payment comes entirely from the Federal share of the recovery.

A State may enforce third party responsibility (other than medical support payment) in either of two ways. Under the "cost avoidance" method, the State denies reimbursement of claims for which potential third party liability is known to exist and instructs the provider to bill the responsible party. Under the "pay-and-chase" method, the State pays the claims and then seeks to collect from the responsible party on its own (unless the State concludes that the cost of collection is greater than the potential recovery). "Pay-and- chase" is mandatory for two kinds of claims: claims for prenatal or preventive pediatric care (including EPSDT services) and claims involving late payment by a third party whose liability arises from a child support action. For all other kinds of claims, the statute permits the State to choose either approach. However, the Secretary has required by regulation that a State must use the cost avoidance method whenever possible unless it can demonstrate that its pay-and-chase system is equally cost-effective. As of December 1987, all States had shifted to a cost avoidance system as their basic method for enforcing third party liability. Sixteen States continue to use pay-and-chase for pharmacy services only; two use pay-and-chase for certain other service types.[19]

Some private health insurance policies have provisions which exclude coverage for any service which might be paid for by Medicaid. No Federal funding is available if a State pays for a service which would have been covered by the private policy but for such a provision.

One possible consequence of a cost avoidance system is that the provider will treat the beneficiary as a private patient and seek to collect from the beneficiary any difference between the amount received from the third party payor and the provider's usual charge. COBRA prohibits collection from the beneficiary if the third party payment is equal to the Medicaid rate for the service; if the payment is below the Medicaid rate, the provider may collect no more than the amount of any beneficiary cost-sharing permitted under the State plan. The State may recover triple the amount of the excess charge from any provider who violates this provision.

A second consequence of a cost avoidance system is that many claims are submitted directly by providers to the liable third parties; the State may never receive information about the services furnished or the amounts paid by the third parties. As a result there is no way of measuring the full impact of third party payments on Medicaid expenditures. HCFA reports that States' direct collections from third parties totalled $107 million in fiscal year 1987. Estimates by States of the amounts saved through cost avoidance totalled $1.1 billion in the same year.[20]

C. Indian Health Service

The Indian Health Service (IHS) within the Department of Health and Human services provides or purchases health services for certain groups of Indians, some of whom may also be eligible for Medicaid.

The IHS provides care in two different ways: directly through IHS-operated facilities on reservations, and on a "contract care" basis through referral to off-reservation health care providers. Services in IHS facilities are available free of charge to any eligible Indian or Alaskan Native, regardless of tribal enrollment status or place of residence. Services through contract care providers are paid for by IHS only for certain designated groups, chiefly on-reservation Indians, when they are unable to obtain needed care through IHS facilities.

The IHS requires that alternative payment resources available to users of IHS services be exhausted before IHS will accept financial responsibility. In the case of services provided in IHS facilities to Medicaid-eligible Indians, IHS bills Medicaid directly. Federal matching funds for services in IHS facilities are available at 100 percent, rather than at the State's usual matching rate.[21] When services are furnished by a contract provider, the provider is expected to collect from any "alternative resource" available to the patient, including Medicaid, Medicare, or other health insurance, before seeking reimbursement from IHS. If Medicaid is the responsible payor, Federal funding is available at the State's usual matching rate; the State is liable for the remainder, as with any other Medicaid service.

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[19] Personal communication, John Thomas, Bureau of Program Operations, HCFA.

[20] Unpublished report, HCFA. The report includes State by State breakdowns. These are not provided here because States did not use uniform methods for estimating cost avoidance.

IV. NOTE ON SOURCES

The information on State reimbursement methodologies presented in the text and in tables V–1 through V–4 has been compiled by the Congressional Research Service through a comparison of several independent reference sources. The most important of these is the Health Care Financing Administration's (HCFA) *Analysis of State Medicaid Program Characteristics: 1986.* [Baltimore, 1987] HCFA conducted a survey of the States that included questions about their reimbursement methodologies as of March 1986.

The HCFA survey is the only comprehensive resource that provides a uniform set of data furnished directly by States and representing State policies at a fixed point in time. In some areas, however, the survey information is insufficient to provide a clear picture of the variation in State reimbursement practices. It has therefore been necessary to supplement the HCFA data with information from other sources. These include:

- The Commerce Clearing House (CCH) *Medicare and Medicaid Guide.* [Chicago, updated weekly] The CCH guide includes summaries of State policies drawn directly from State Medicaid plans and regulations. The summaries are updated at irregular intervals. Some date from 1985, while others are current as of 1988.
- Two series of intermittent reports on State policy changes, the National Governors' Association's *Catalogue of State Medicaid Program Changes* [Washington, 1981–88] and the Intergovernmental Health Policy Project's *Major Changes in State Medicaid and Indigent Care Programs* [Washington, 1981–87]. Both series are based on information provided by States about changes in the State Medicaid plan, law, or regulations during a particular period, such as a calendar year. Neither series includes information about States that did not change their policies in the particular period covered.

Unlike the HCFA survey, none of the supplementary sources permits a comparison of practices in all States at a single point in time. The data presented in this report reflect the most current information available at the end of Federal fiscal year 1987. In addition, because the supplementary sources are drawn from State documents rather than from a uniform survey instrument, it is not always possible to determine whether apparent variations in payment practices reflect real differences or merely differences in the terminology adopted by particular States. The basic system descriptions provided by States in the 1986 HCFA survey have been used in cases in which the information from other sources was unclear or contradictory.

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[21] The payment is not actually issued to the facility but is retained by the Secretary of Health and Human Services in a special fund for the purpose of improving IHS facilities.

CHAPTER V. ALTERNATE DELIVERY OPTIONS AND WAIVER PROGRAMS [1]

SUMMARY

Medicaid law provides a number of options for States wishing to use innovative methods of delivering or paying for Medicaid services. Since the earliest years of the Medicaid program, States have arranged for the enrollment of Medicaid beneficiaries under contracts with health maintenance organizations (HMOs) or comparable organizations. The Omnibus Budget Reconciliation Act of 1981 (OBRA81, Public Law 97-35) established two new options, section 2175 (freedom of choice) and 2176 (home and community-based services) waiver programs. Under these provisions, the Secretary could waive certain statutory requirements in order to allow States to develop cost-effective alternative methods of service delivery or reimbursement. The purpose of the provisions was to give States greater flexibility in managing their Medicaid programs. In the case of the 2175 waiver option, the greater flexibility was intended to offset the temporary reductions in Federal Medicaid funding imposed by the same Act. The section 2176 option was intended to correct a perceived "institutional bias" in Medicaid services for the chronically ill by allowing community-based alternatives. Finally, States have periodically been granted waivers of Medicaid requirements in order to conduct demonstration projects. Some of these projects have been authorized by the Secretary under general statutory provisions allowing for tests of possible program improvements. Others have been specifically authorized by Federal legislation.

This chapter describes each of the four basic types of Medicaid alternate delivery options:

- Risk contracts with health maintenance organizations (HMOs) and comparable organizations known as prepaid health plans (PHPs).
- Freedom of choice (section 2175) waivers.
- Home and community-based services waivers, including section 2176 waivers, model waivers, and the new waiver program for the elderly and for "boarder babies" established by recent legislation.
- Special demonstration projects authorized by the Secretary under general waiver authorities or specifically mandated by Congress.

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[1] This chapter was written by Mark Merlis.

I. RISK CONTRACTS

States may enter into risk contracts with health maintenance organizations (HMOs) or comparable entities. Under a risk contract, the organization agrees to make available a specified set of medical services to an individual beneficiary in return for a fixed periodic payment issued by the Medicaid program on the beneficiary's behalf. The payment, known as a premium or capitation payment, is usually issued monthly, at a rate based on a projection of costs for the services used by a typical patient. If the beneficiaries enrolled under the contract use more, or more costly, services than anticipated, the organization may suffer a loss. If the enrollees use fewer services than anticipated, the organization may realize a profit. The organization is therefore said to be "at risk" for the set of services covered by the contract.

The risk arrangement is intended to give the organization a financial incentive to furnish services more efficiently. The beneficiaries who are enrolled may obtain services covered under the contract only from providers affiliated with the organization, except in emergencies or for family planning services. As an incentive for participation, the State may arrange for an HMO to offer additional services not ordinarily covered by the Medicaid program, or the HMO may offer these services on its own. The State is not required to furnish the additional services to beneficiaries who are not enrolled under the risk contract.

The requirements governing risk contracts depend on the scope of services that the contractor has agreed to cover. A "comprehensive" contract is one in which the organization has agreed to accept risk for any three of the mandatory Medicaid services (see Chapter III), or for inpatient hospital care and any other mandatory service. Comprehensive contracts are subject to specific requirements set forth in section 1903(m) of the Social Security Act. A few States have entered into "partial capitation" arrangements, under which the organization contracts for a more limited scope of services. Such a contract might cover only physician and diagnostic services, or only dental care. No specific requirements for these contracts are included in Medicaid law, although they are subject to some regulatory requirements. Of the approximately one million Medicaid beneficiaries receiving services through risk contractors in December 1987, 95 percent were enrolled under comprehensive contracts (see Appendix F for enrollment by State). For this reason, the following discussion is confined to the requirements governing contracts subject to section 1903(m).

A State may enter into a 1903(m) comprehensive risk contract with two kinds of entities: HMOs and "prepaid health plans" (PHPs).[2]

An HMO may be Federally qualified—determined by the Secretary to meet standards set forth in Title XIII of the Public Health Service Act—or may be certified as eligible by the State.[3] A State-

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[2] The law continues to provide for contracts with another kind of entity, "provisionally qualified" HMOs, but no organizations are known to be in this category; see Appendix F for a discussion of this provision.

[3] Federally qualified HMOs are certified by HCFA as meeting certain financial, organizational, and quality standards. A qualified HMO is permitted to take advantage of the "dual choice"

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certified HMO must (a) be organized primarily for the purpose of providing health care services, (b) make the services it provides as accessible to enrollees as they are to nonenrolled beneficiaries, and (c) provide satisfactory assurances that beneficiaries will not become liable for the HMOs debts in the event that it becomes insolvent.

PHPs include community, migrant, or Appalachian regional health centers which receive Federal grant funds and meet certain other conditions. Some entities which entered into a risk contract prior to 1970 may also be treated as PHPs.

No more than 75 percent of the enrollees of an HMO may be Medicaid or Medicare beneficiaries. This requirement may be waived for PHPs. It may be waived temporarily for publicly owned HMOs, HMOs with more than 25,000 enrollees that serve a designated "medically underserved" area and that previously participated in an approved demonstration project, or HMOs that have had a Medicaid contract for less than 3 years. Waivers for HMOs are permitted only if the Secretary determines that special circumstances warrant the exemption and that the HMO is making efforts to comply with the 75 percent limit.[4]

Beneficiaries joining an HMO must ordinarily be permitted to disenroll at any time and return to ordinary Medicaid status; the withdrawal must take effect by the end of the month following the month in which disenrollment is requested. An exception to this rule is allowed for Federally qualified HMOs and certain PHPs (but not for State-certified HMOs). The State may restrict the enrollee's ability to disenroll from one of these organizations for a 5-month period, following a 1-month trial period. Disenrollment must be permitted at any time for cause; e.g., if the enrollee moves out of the area served by the HMO. The restriction may be renewed every 6 months, again with a 1 month period during which the beneficiary may disenroll without cause. For the same groups of organizations, with minor exceptions, the State may also provide for "guaranteed eligibility." For a period of up to 6 months from the date of initial enrollment, the State may continue premium payments to the HMO or PHP on behalf of an enrollee, even if the enrollee ceases to be eligible for Medicaid during that period.

Premium rates must be established on an actuarially sound basis. The Secretary has provided by regulation that rates may not exceed what has come to be known as the "fee-for-service equivalent." This is the amount which the State would have spent to provide the set of services covered by the HMO or PHP to an equivalent group of beneficiaries not enrolled in the organization and continuing to receive care on a fee-for-service basis. Conceptually, the fee-for-service equivalent is identical to the adjusted average per capita cost (AAPCC) used in calculating Medicare premium rates

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provisions of Title XIII. An employer with more than 25 employees that is subject to the Fair Labor Standards Act and that provides health insurance benefits is required to offer an HMO option as an alternative to its standard health plan, if a federally qualified HMO is available in its area and asks to be included.

[4] Note that the 75 percent limit under Medicaid law is different from the rule for Medicare HMO contractors, which must generally have no more than 50 percent Medicaid or Medicare enrollees. Some HMOs contracting with Medicare are exempt from Medicare's 50 percent limit (these include contractors paid on a reasonable cost basis under section 1833 of the Social Security Act) but are subject to the higher limit under Medicaid.

for HMOs. However, whereas Medicare premiums are fixed at 95 percent of the AAPCC, Medicaid payments may be at any level up to 100 percent of the fee-for-service equivalent; it is a ceiling rather than a basis for rate-setting. Some States do use the fee-for-service equivalent, or a percentage of this figure, as a premium rate. Others negotiate rates or set them on the basis of competitive bidding, while a few have developed more complex actuarial projection methodologies.

Since 1986, Congress has added to the law a number of provisions intended to improve quality of care in prepaid programs or protect beneficiaries. States are now required to obtain an independent assessment of the quality of services furnished by contracting HMOs and PHPs, using either a utilization and quality control peer review organization (PRO) under contract to the Secretary or another independent accrediting body. In addition, States are prohibited from contracting with an organization which is managed or controlled by, or has a significant subcontractual relation with, individuals or entities potentially excludable from participation in Medicaid or Medicare (see Chapter VI for a discussion of the grounds for exclusion).

HMOs and PHPs that commit certain violations may also be subject to special monetary penalties or other sanctions, in addition to the general sanctions applicable to all Medicaid providers. Civil monetary penalties may be imposed on organizations that fail to furnish medically necessary services or, beginning in April 1990, that make incentive payments to physicians to reduce services to enrollees.[5] Organizations may also be penalized for imposing illegal premiums on enrollees, discriminating in enrollment on the basis of health status, or supplying false information to the Secretary, the State, or any other individual or entity. (Details of the penalty provisions are included in the general discussion of civil monetary penalties in Chapter VI.)

In addition, the Secretary may deny Federal funding for Medicaid premiums paid on behalf of new enrollees joining the HMO after the date the Secretary notifies the HMO that it has committed a violation. The denial may continue until the Secretary is satisfied that the basis for the violation has been corrected and that the problems are not likely to recur.

II. FREEDOM OF CHOICE (SECTION 2175) WAIVERS

Section 2175 of OBRA81 authorized the Secretary to waive certain provisions of Medicaid law to allow States to develop innovative health care delivery or reimbursement systems. The so-called "2175" waiver program originally allowed for waivers of any provision of section 1902 of the Social Security Act, relating to basic requirements for State Medicaid plans, or section 1903(m),[6] relating to requirements for contracts with HMOs or PHPs, in order to allow a State to:

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[5] The effective date for the physician incentive penalties was originally Apr. 1989. The Secretary was required to report to Congress, no later than Jan. 1, 1988, on the nature of physician incentive plans currently used by HMOs and to recommend reasonable exceptions to the prohibition of such plans. The report has not been filed as of June 1988. OBRA87 changed the effective date of the penalties in order to allow Congress time to consider the Secretary's recommendations once the report is submitted.

[6] The authority to waive section 1903(m), relating to requirements for HMOs and other risk contractors, was repealed by the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). See Appendix F for a discussion of the reason for and impact of this change.

1. Implement a primary care case management program or specialty physician services arrangement which restricts the providers from whom a beneficiary may obtain covered services.

Under a primary care case management program, each participating beneficiary selects or is assigned to a single primary care provider. Except in an emergency, the beneficiary may obtain other services, such as specialty physician and hospital care, only with the authorization of the primary care provider. The aim of the program is to reduce the use of unnecessary services and provide better overall coordination of beneficiaries' care. Under a specialty physician services arrangement, beneficiaries could obtain specialty care only from a limited group of physicians selected by the State, perhaps on the basis of fee levels or cost-effective practice patterns (no State has implemented a program of this kind). Of the 23 section 2175 waivers operational in February 1988, 21 are for case management.

2. Use a local agency as a "central broker" to assist beneficiaries in choosing among competing health care plans.

Under this option, a State may establish a limited number of alternative health plans in an area and require Medicaid beneficiaries to choose from among those plans. For example, the State might offer a choice among several HMOs or PHPs and a fee-for-service primary care case management program. Waivers for this purpose are ordinarily granted in conjunction with case management waivers. Two programs had both types of waivers in February 1988.

3. Share with beneficiaries, through the provision of additional services, savings resulting from the beneficiaries' use of cost-effective providers.

A beneficiary participating in a primary care case management program might, for example, receive expanded dental coverage or a waiver of required cost-sharing as an incentive to enroll. (Note that no waiver is required when additional services are made available to enrollees of an HMO or PHP.) Waivers for this purpose are also granted in conjunction with case management waivers. Three programs had both types of waivers in February 1988.

4. Restrict the providers from whom beneficiaries may receive services, except in emergencies, to those meeting reimbursement, quality, and utilization standards established by the State.

A State may use this option to establish a selective contracting program, such as the California and Illinois systems of competitive negotiations for inpatient hospital services described in chapter IV. Other States have combined selective contracting with primary care case management programs to establish coordinated care systems. Two States have waivers for restriction of providers alone, while seven waiver programs restrict providers in the context of a case management program.

There are three statutory provisions for which section 2175 waivers have most frequently been granted. The first is *freedom of choice,* the requirement that beneficiaries be able to obtain covered services from any qualified provider willing to accept Medicaid reimbursement. Waiver of this requirement has, for example, permitted States to mandate beneficiary enrollment in case management systems. (As with HMO contracts, the beneficiary's right to select a provider of family planning services may not be restricted.) Waiver of this rule is so common a feature of section 2175 programs that they are often spoken of generically as "freedom of choice waivers." The other two statutory provisions often waived are *comparability* and *statewideness,* the requirements that the scope of covered services be the same for all categorically needy beneficiaries and that the Medicaid program operate uniformly throughout the State. Waiver of these requirements has allowed States to target section 2175 programs to particular groups of beneficiaries, such as AFDC recipients in a particular county.

In requesting a 2175 waiver, the State must demonstrate that its proposed program will be cost-effective and must provide assurances that the restrictions established by the waiver will not impair beneficiaries' access to medically necessary services of adequate quality. Waivers are deemed granted unless the Secretary denies the request or asks for additional information within 90 days. The maximum period for which waivers may be granted is 2 years, but waivers may be renewed after a reapplication process.

Table V–1 shows the types of programs for which section 2175 waiver proposals—including those withdrawn, disapproved, or never implemented—have been submitted to the Secretary from 1981 through 1987. Of the 95 separate requests, 42 were approved. Most approved waiver proposals have related to primary care case management and other "managed care" programs. Table V–2 shows the current status of those proposals that were actually implemented, while Table V–3 shows the States with operational programs in February 1988 and the nature of the waivers for those programs. Of the 23 operational programs, 18 were managed care programs; details of these programs are provided in Appendix F. The other five projects included the two selective contracting systems for hospital care in California and Illinois, a prepaid dental care plan in Oregon, and two special case management programs: in Minnesota, for substance abusers, and in South Carolina, for high risk pregnancies.

Table V–1.—WAIVER REQUESTS UNDER SECTION 2175, 1981–87

	1981	1982	1983	1984	1985	1986	1987	Total
Managed care:								
Approved	3	9	5	2	3	3	0	25
Disapproved/withdrawn	0	1	1	1	0	1	0	4
Pending 2/88	0	0	0	0	2	[1] 2	1	5
Selective contracting:								
Approved	0	3	1	4	0	0	0	8
Disapproved/withdrawn	0	2	3	3	1	3	0	12
Pending 2/88	0	0	0	0	1	2	2	5
Waive 1903(m) HMO rules:								
Approved	1	3	0	0	0	0	0	4

Table V–1.—WAIVER REQUESTS UNDER SECTION 2175, 1981–87—Continued

	1981	1982	1983	1984	1985	1986	1987	Total
Disapproved/ withdrawn	0	3	0	0	0	0	0	3
Pending 2/88	0	0	0	0	0	0	0	0
Other: [2]								
Approved	0	1	1	1	0	1	1	5
Disapproved/withdrawn	0	1	3	0	2	1	0	7
Pending 2/88	0	0	0	0	0	1	1	2
Nonresponsive [3]	6	6	1	0	0	2	0	15
Total requests [4]	10	29	15	11	9	16	5	95

[1] One of the pending requests was for approval of New Jersey's Garden State Health Plan project. The Omnibus Budget Reconciliation Act of 1987 authorizes New Jersey to operate the project without waivers, rendering the request moot.

[2] Requests labeled as "other" were generally for projects involving the management of a special population, such as the mentally ill or high-risk pregnancies, or for case management involving ancillary services, such as dental care.

[3] Requests labeled as "nonresponsive" were for purposes other than those specified in section 2175 or required waivers of provisions of law for which waivers were not authorized by that section. Among these were proposals to impose new copayment requirements on beneficiaries or to waive eligibility rules.

[4] Excludes two waiver requests which extended existing projects with minor changes.

Source: Congressional Research Service analysis of unpublished Health Care Financing Administration reports.

Table V–2.—STATUS OF APPROVED SECTION 2175 WAIVERS, FEBRUARY 1988

	Still in initial waiver period	Operating under approved renewal	Terminated or expired
Managed care	7	11	7
Selective contracting	0	2	6
1903(m) HMO requirements	0	0	4
Other	2	1	2
Total	9	14	19

Source: Congressional Research Service analysis of unpublished Health Care Financing Administration reports.

Table V–3.—LOCATION AND TYPE OF OPERATIONAL SECTION 2175 WAIVER PROGRAMS, FEBRUARY 1988

	Case Management	Locality as Central Broker	Share Savings	Restrict Providers
California (4):				
1. Primary Care Case Management	X			
2. Selective Hospital Contracting				X
3. San Mateo Organized Health System	X			X
4. Santa Barbara Health Initiative	X			X
Colorado: Primary Care Case Management	X			
Connecticut: Primary Care Network	X			
Illinois: Illinois Competitive Access & Reimbursement Equity Program				X
Kansas: Kansas Primary Care Network	X			
Kentucky: KENPAC	X			
Michigan (2):				
1. Primary Care Physician Sponsor Program	X			
2. Capitated Ambulatory Program	X			
Minnesota: Case Management for Chemical Dependency or Abuse	X			X
Missouri: Medicaid Managed Health Care Plan	X	X		
Nevada: Primary Care Case Management Program	X			
New York: PCMP—Erie	X			

Table V-3.—LOCATION AND TYPE OF OPERATIONAL SECTION 2175 WAIVER PROGRAMS, FEBRUARY 1988—Continued

	Case Management	Locality as Central Broker	Share Savings	Restrict Providers
Oregon (2):				
1. Capitated Physician Case Management Program	X			
2. Dental Capitation	X			X
Pennsylvania: HealthPass	X		X	X
South Carolina: High Risk Channeling Project	X		X	X
Tennessee: Primary Care Case Management	X			
Utah: Choice of Health Care Delivery System	X	X		
Washington: KPS Capitation Plan	X			
Wisconsin: HMO Primary Care Case Management	X		X	X
Total	21	2	3	9
Number of States with programs: 18				

Source: Congressional Research Service analysis of unpublished Health Care Financing Administration reports.

III. HOME AND COMMUNITY-BASED SERVICES WAIVERS

The second new option established by OBRA81 was the section 2176 home and community-based services waiver program, which allows States to provide a coordinated set of noninstitutional services for a specified group of individuals (such as the aged or disabled) who would otherwise be at risk of institutionalization, or who are already receiving institutional care and need help to return to the community. Public Law 100-203, the Omnibus Budget Reconciliation Act of 1987 (OBRA87) has established a new home and community-based services waiver authority that is similar to the section 2176 program but is available only for persons over age 65.

Programs under the two home and community-based services authorities differ from the section 2175 programs described above in two major ways. First, they are specifically targeted at segments of the Medicaid population likely to require long-term care, while section 2175 programs are aimed at AFDC recipients or the general Medicaid population. Second, section 2176 programs provide a range of services to the beneficiaries participating in them that may not be available to other beneficiaries. Section 2175 programs seek to modify the way beneficiaries obtain the services already available to them.

A. 2176 WAIVERS

1. BASIC RULES

A 2176 waiver program provides services to a target population defined by the State. This target population may include the aged, the disabled, the mentally retarded, the chronic mentally ill, persons with AIDS, or any other population identified by the State as likely to require extended care in hospitals or nursing facilities. Participation in section 2176 programs may be limited to persons in a specified geographic area. States may also limit the total number of persons to be served.

The package of services made available to waiver participants may include optional Medicaid services that are not made available to other Medicaid beneficiaries under the State plan, as well as services that are not strictly medical in nature and would therefore not qualify for ordinary Medicaid coverage.

A State which has not elected to cover certain Medicaid optional services, such as hospice care, or which has limited coverage of mandatory services such as home health care, may wish to expand those services for its defined target population. Ordinarily, the statewideness and comparability rules would require the State to offer any new services to all categorical eligibles. A waiver permits the State to offer the services only to the target group. The optional services which may be included are: homemaker/home health aide and personal care services, medical day care services, hospice care, and partial hospitalization and clinic services for the chronically mentally ill.[7]

The State may also wish to include in its care system certain social or medical-social services that can help individuals remain in the community. Services that are not clearly medical in nature would ordinarily be excluded from Medicaid coverage. Those that may be included under a 2176 waiver, and that could not otherwise be covered, are: (i) respite care, services that allow family or other voluntary caregivers to take time away from their responsibilities for a patient's care; (ii) habilitation services, which improve the participant's social and adaptive skills; (iii) psychosocial rehabilitation for the mentally ill; and (iv) any other services (other than room and board) requested by the State and approved by the Secretary. Many section 2176 programs also include case management services, which help coordinate medical and social services. These could formerly be offered only under a waiver, but may now be covered as an optional service for target groups without a waiver.[8]

In addition to offering greater flexibility in the provision of services, a section 2176 waiver may allow the State to provide Medicaid services to persons who would otherwise be ineligible. The State may determine eligibility for waiver participants using the financial standards which would apply if they were in an institution, as opposed to the standards applicable to beneficiaries in the community. As chapter II indicates, States may use a higher income standard for institutionalized applicants than for those living in the community. The institutional standard may be as high as 300 percent of the State's SSI standard. Use of the higher institutional standard for waiver participants remaining in the community means that the State can intervene with services to prevent the institutionalization of persons who, if they entered an institution, would qualify for Medicaid.

In order to obtain a waiver, the State must show that its project will be "budget neutral." The projected average per capita costs for persons receiving services under the waiver may not exceed the costs that would have been incurred for the same individuals if the waiver had not been granted. (The State cannot later be penalized if these projections prove mistaken.) States may exclude from waiver participation individuals for whom the cost of waiver services is likely to exceed the cost of institutionalization.

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[7] Several of these services are not specifically included in the standard listings of optional services in Medicaid law and regulations. However, the Secretary has approved them as part of individual States' Medicaid plans under a general authority to cover "any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary."

[8] This form of "case management," whose goal is to facilitate and coordinate access to services, is different from the case management provided under primary care case management systems, whose aim is to limit or control unnecessary care.

Provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, Public Law 99-272) ensure that, for the purposes of the budget neutrality test, States may use a comparison population which closely resembles the actual population to be served under the waiver. For example, if the waiver is to serve disabled persons who would otherwise be in nursing homes, the State may compare projected costs for the waiver participants to costs for disabled persons in nursing homes, rather than all persons in nursing homes.[9]

The budget neutrality test has presented problems for States that have limited new construction of nursing home beds, or have actually closed beds in such facilities as ICFs/MR. If there are few vacant beds left in the State, the State may have difficulty showing that its waiver program is saving money by preventing people from entering nursing homes; many of the participants in the waiver program could not have entered a nursing home in any event. For this reason, the number of participants in a waiver program has been limited to the number of persons who would in fact have been served in a Medicaid nursing home bed in the absence of a waiver.

Two provisions of recent legislation are intended to address this problem. First, OBRA87 established a new waiver authority, distinct from the 2176 authority, for services to the aged. The new 1915(d) waivers are described below. Second, the Medicare Catastrophic Coverage Act (Public Law 100-360) changes the budget neutrality test for programs designed to serve the mentally retarded. The State may compare projected costs under the waiver to costs that would have been incurred for the same individuals if they had entered a nursing facility, without regard to the availability of nursing facility beds in the State.

The State must evaluate potential waiver participants and determine which of them may require the level of care provided by a hospital, nursing facility, or intermediate care facility for the mentally retarded. Individuals who meet this level of care test (or their representatives) must be informed of the availability of community alternatives, but cannot be required to participate in the waiver program. The State must provide assurances that safeguards are in place to protect the health and welfare of waiver participants.

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[9] OBRA87, as modified by Public Law 100-360, also provides for a less restrictive budget neutrality test for waiver programs intended to serve the developmentally disabled who are in ordinary nursing facilities but who require the level of care provided by intermediate care facilities for the mentally retarded (ICFs-MR). Waiver costs may be compared to the costs that would have been incurred if the participants had been treated in ICFs-MR, even if the bed capacity of the State's ICFs-MR would not have accommodated all the participants. This allows States to develop waiver services for developmentally disabled persons determined to be inappropriately placed in ordinary nursing homes and in need of alternative placement. The provision thus complements the requirement, included in the OBRA87 nursing home reforms, that States review the needs of all mentally retarded persons in nursing homes and find alternative placements for those inappropriately placed (see Chapter VI).

Waivers may be granted for an initial period of 3 years; waiver renewals are for a 5 year term. As with 2175 waivers, a 2176 waiver is deemed granted unless the Secretary issues a denial or requests additional information within 90 days after receiving the State's request.

2. MODEL WAIVERS

"Model waivers" are a separate category of 2176 waivers created by HCFA to deal with an eligibility problem faced by certain disabled persons, chiefly children. If a child lives at home, the parents' financial resources are deemed to be available for the child's medical care. If the same child is institutionalized, after the first month away from home only the child's own financial resources are deemed to be available for the child's care. The child may then qualify for Medicaid. Because of these "deeming" rules, some children who could have been cared for at home might remain in institutions because, if they were to return home, they would lose Medicaid benefits.

A model waiver allows a State to waive the deeming rules and pay for support services to help keep children at home. The State must show that the costs of these services are no more than would have been spent if the child were institutionalized.

Originally, the number of persons who could participate under a model waiver was limited to 50. If the State wished to cover additional individuals, it was obliged to apply for another waiver. OBRA87, as modified by Public Law 100–360, provides that the Secretary may not limit coverage under any 2176 waiver to fewer than 200 persons; the State may still impose a lower limit if it chooses.

Some disabled noninstitutionalized children who would formerly have been eligible for Medicaid only under a model waiver may instead, as a result of a change included in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA, Public Law 97–248), be covered as an optional eligibility group without a waiver. If a State elects this option, however, it must grant eligibility to all children who qualify, rather than to a limited number. (See chapter II.) Twenty-two States have chosen this approach, as opposed to the seventeen with model waivers (see below).

3. CURRENT WAIVER PROJECTS

Table V–4 shows the States that had operating section 2176 waiver projects as of February 1988. Forty-two States had a total of 86 regular section 2176 programs. Of the 86 programs, 42 served the aged and disabled, 35 the developmentally disabled and mentally retarded, and 3 served both groups. Four programs served persons with AIDS and related conditions, one program served chronically ill children, and one served the mentally ill. In addition, seventeen States had a total of 20 model waiver programs.

Table V–5 shows the number of programs serving each major target population and the kinds of additional services provided under these programs. (One service not shown on the table, hospice care, was offered as a waiver service only by Kansas.) As the table indicates, the nature of the services provided tends to vary according to the population being served. Programs targeted at the frail elderly are more likely to include support services to help the clients with activities of daily living, such as homemaker, home health aide, and personal care services. Programs targeted at disabled populations are more likely to offer habilitation services, which help clients develop the skills they will need to live in community settings.

Finally, table V–6 shows the number of persons served and total expenditures under section 2176 waiver programs in fiscal year 1986 (note that none of the current programs for persons with AIDS were in operation during that year).

Table V–4.—SECTION 2176 WAIVER PROGRAMS IN OPERATION, FEBRUARY 1988

State	Regular 2176 Programs		Model Waivers
	Number	Populations	
Alabama	2	A/D, MR/DD	
California	6	A/D, MR/DD	1
Colorado			1
Connecticut	2	A/D	1
Delaware	2	A/D, MR/DD	
Florida	5	A/D, MR/DD	
Georgia	1	A/D	2
Hawaii	4	A/D, MR/DD, AIDS	
Idaho	1	A/D, MR/DD	1
Illinois	3	A/D, MR/DD	1
Indiana	1	A/D	
Iowa			1
Kansas	1	A/D, MR/DD	
Kentucky	2	A/D, MR/DD	1
Louisiana	1	A/D	
Maine	2	A/D, MR/DD	
Maryland	2	MR/DD, <21	1
Massachusetts	2	A/D, MR/DD	
Michigan	1	MR/DD	1
Minnesota	3	A/D, MR/DD	1
Mississippi	1	A/D	
Missouri	2	A/D, MR/DD	
Montana	2	A/D, MR/DD	
Nebraska	1	MR/DD	
Nevada	2	A/D, MR/DD	
New Hampshire	2	A/D, MR/DD	
New Jersey	3	A/D, MR/DD, AIDS	1
New Mexico	4	A/D, MR/DD, AIDS, <21	
New York	1	A/D	1
North Carolina	2	A/D, MR/DD	1
North Dakota	2	A/D, MR/DD	
Ohio	2	A/D, AIDS	3
Oklahoma	1	MR/DD	
Oregon	2	A/D, MR/DD	
Pennsylvania	2	A/D, MR/DD	
Rhode Island			1
South Carolina	1	A/D	
South Dakota	1	MR/DD	
Tennessee	3	A/D, MR/DD	
Texas			1
Utah	1	MR/DD	
Vermont	3	A/D, MR/DD, MI	
Virginia	1	A/D	
Washington	2	A/D, MR/DD	

Table V–4.—SECTION 2176 WAIVER PROGRAMS IN OPERATION, FEBRUARY 1988—Continued

State	Regular 2176 Programs		Model Waivers
	Number	Populations	
West Virginia	2	A/D, MR/DD	
Wisconsin	3	A/D, MR/DD	
Total	86		20

A/D—Aged/disabled
MR/DD—Mentally retarded/developmentally disabled
AIDS—Acquired immunodeficiency syndrome/AIDS-related complex
<21—Chronically ill children
MI—Mentally ill

Source: Congressional Research Analysis of unpublished Health Care Financing Administration reports.

Table V–5.—SECTION 2176 WAIVER SERVICES AND TOTAL WAIVERS BY POPULATION SERVED, PROGRAMS OPERATIONAL IN FEBRUARY 1988

	Case management	Homemaker	Home health aide	Personal care	Adult day care	Habilitation	Respite	Total
Aged/disabled (A/D)	36	28	12	20	30	2	28	42
Mentally retarded/developmentally disabled (MR/DD)	28	10	3	10	12	29	26	35
Both A/D and MR/DD	2	2	1	2	1	1	1	3
AIDS/ARC	4	2	1	4	4	1	2	4
Children	2	1	2	1	0	0	0	1
Mentally ill	1	0	0	0	1	1	1	1
Model waivers	14	5	3	12	2	3	9	20
Total	87	48	22	49	50	37	67	106

Source: Congressional Research Service analysis of unpublished Health Care Financing Administration reports.

Table V–6.—EXPENDITURES AND BENEFICIARIES FOR 2176 WAIVER SERVICES, FISCAL YEAR 1986

State	Aged/Disabled			Developmentally disabled/chronically mentally ill		
	Total waiver expenditures	Total unduplicated waiver beneficiaries	Expenditures per beneficiary	Total waiver expenditures	Total unduplicated waiver beneficiaries	Expenditures per beneficiary
Alabama	$9,609,851	3,624	$2,652	$7,831,197	1,592	$4,919
Alaska	0	0	N/A	0	0	N/A
Arkansas	0	0	N/A	0	0	N/A
California	[1] 15,927,215	[1] 6,466	2,463	26,215,375	3,115	8,416
Colorado	8,353,500	3,300	2,531	22,700,283	1,435	15,819
Connecticut	998,331	723	1,381	0	0	N/A
Delaware	0	0	N/A	[4] 559,502	[4] 80	6,994
District of Columbia	0	0	N/A	0	0	N/A
Florida	[1] 7,657,621	[1] 8,076	948	16,705,100	7,506	2,226
Georgia	9,096,391	5,322	1,709	0	0	N/A
Hawaii	[1] 1,664,022	[1] 244	6,820	410,542	46	8,925
Idaho	998,302	329	3,034	418,740	138	3,034
Illinois	24,351,792	12,483	1,951	[4] 7,187,283	[4] 585	12,286
Indiana	17,474	39	448	0	0	N/A
Iowa	0	0	N/A	0	0	N/A
Kansas	[3] 2,052,083	[3] 958	2,142	1,680,514	585	2,873
Kentucky	493,696	358	1,379	9,670,896	567	17,056
Louisiana	788,010	305	2,584	0	0	N/A
Maine	831,878	1,080	770	4,037,620	383	10,542
Maryland	0	0	N/A	16,743,168	604	27,720

Table V-6.—EXPENDITURES AND BENEFICIARIES FOR 2176 WAIVER SERVICES, FISCAL YEAR 1986—Continued

State	Aged/Disabled			Developmentally disabled/chronically mentally ill		
	Total waiver expenditures	Total unduplicated waiver beneficiaries	Expenditures per beneficiary	Total waiver expenditures	Total unduplicated waiver beneficiaries	Expenditures per beneficiary
Massachusetts	4,000,000	1,900	2,105	11,102,253	520	21,350
Michigan	0	0	N/A	0	0	N/A
Minnesota	3,621,222	1,662	2,179	5,939,033	[4] 817	7,269
Mississippi	0	0	N/A	0	0	N/A
Missouri	[1] 2,982,495	[1] 4,150	1,387	0	0	N/A
Montana	[3] 1,322,434	[3] 306	4,322	3,426,684	201	17,048
Nebraska	0	0	N/A	0	0	N/A
Nevada	0	0	N/A	1,413,467	135	10,470
New Hampshire	242,072	157	1,542	10,706,228	503	21,285
New Jersey	8,544,333	2,197	3,889	22,893,275	2,058	11,124
New Mexico	[4] 2,018,839	[4] 419	4,818	[4] 545,121	[4] 85	6,413
New York	1,915,929	4,453	430	0	0	N/A
North Carolina	4,463,190	1,171	3,811	2,311,268	321	7,200
North Dakota	[4] 342,407	[4] 188	1,821	[4] 3,795,931	[4] 608	6,243
Ohio	1,582,859	559	2,832	0	0	N/A
Oklahoma	0	0	N/A	180,985	[4] 146	1,240
Oregon	[3] 17,562,604	[3] 7,172	2,449	[1] [5] 5,405,525	[1] 1,478	3,657
Pennsylvania	0	0	N/A	[2] 15,453,409	[2] 543	28,459
Rhode Island	[4] 951,900	[4] 437	2,178	[1] [4] 2,010,436	[1] [4] 571	3,521
South Carolina	6,216,411	5,266	1,180	0	0	N/A
South Dakota	0	0	N/A	5,075,497	589	8,617
Tennessee	0	0	N/A	0	0	N/A
Texas	0	0	N/A	542,034	68	7,971
Utah	0	0	N/A	0	0	N/A
Vermont	0	0	N/A	[1] 5,534,590	[1] 263	21,044
Virginia	10,560,328	2,996	3,525	0	0	N/A
Washington	13,089,348	[4] 1,875	6,981	[4] 8,016,485	930	8,620
West Virginia	1,036,297	199	5,208	502,000	55	9,127
Wisconsin	1,146,218	183	6,263	1,653,157	120	13,776
Total/Average	164,439,052	78,597	2,092	220,667,598	26,647	8,281

N/A: Not applicable.

[1] Total value for services provided under two waivers. Values for one Oregon waiver are estimates of A/D component of a combination waiver.
[2] Total value for services provided under five waivers. Beneficiary counts for four of the waivers are for July 1985–June 1986.
[3] Estimated A/D component of services provided by State under a combination waiver. Data are for CY 1986.
[4] Obtained or inferred from HCFA Form 372.
[5] Data for one waiver are from HCFA Form 372.

Source: Clinksdale, Robert and Ray, Sheila S. ***Survey of Medicaid Home and Community-based Care Waivers: FY 1986.*** Medicaid Program Evaluation Working Paper 1.11. La Jolla Management Corporation. Dec. 1987. Exhibits 2–3 and 2–4.

B. Section 1915(d) Waivers for the Aged

OBRA87 established a second home and community-based services program, section 1915(d) waivers for the aged. These waivers are designed to address the situation of States that have restrained nursing home construction. As noted earlier, the number of participants in a section 2176 waiver program is generally limited to the numbers who would actually occupy a Medicaid nursing home bed in the absence of the waiver. The new program exempts a State from this limit. In return, however, the State must agree to put itself at financial risk by accepting a cap or ceiling on its total expenditures for long-term care for the elderly, both those in nursing homes and those served by the waiver.

In other operational aspects, the 1915(d) waivers are similar to the 2176 waivers. The following are the major differences.

a. Under a 1915(d) waiver, total Medicaid expenditures for long-term care services for the aged, whether in a nursing home or in the waiver program, are capped at an amount representing aggregate expenditures for these services prior to the waiver, updated annually for inflation and changes in the size of the State's population aged 65 and over. The annual increase may not exceed 7 percent until 1990, after which "market basket" indices will apply. Under section 2176, the Secretary must approve annual estimates by the State which show that costs for waiver participants only will not exceed the costs that would have been incurred if these persons had been institutionalized. However, actual waiver expenditures are not limited to the advance estimates, and there is no limit to the increase in expenditures for persons remaining in institutions.

b. 1915(d) waivers are available only for coverage of beneficiaries aged 65 or older who would be likely to require nursing home care; 2176 waivers may be obtained for other special populations.

c. The Secretary must provide a 1915(d) waiver to a State meeting the conditions set forth in the statute; denial of a waiver is subject to appeal. 2176 waivers are granted at the discretion of the Secretary.

The Act provides for limited extensions of expiring 2176 waivers to permit States to convert them to 1915(d) waiver programs. As of this writing, only Oregon had applied for a 1915(d) waiver.

C. Section 1915(e) Waivers for "Boarder Babies"

The Medicare Catastrophic Coverage Act of 1988 (Public Law 100–360) establishes a new waiver program targeted at "boarder babies," children who are infected with the acquired immunodeficiency syndrome (AIDS) virus or who are drug dependent at birth and who may remain in hospitals indefinitely because of problems in finding an alternative placement. The new 1915(e) waivers will allow States to provide services to such children, as well as to any children with AIDS, who (i) are under age 5, (ii) are receiving or are expected to receive Federally funded adoption or foster care assistance, and (iii) would be likely, in the absence of waivered services, to require the level of care provided by a hospital or nursing facility. Covered services could include nursing care, physicians' services, respite care, prescription drugs, medical devices and supplies, transportation, and any other service requested by the State and approved by the Secretary.

As with other home and community-based services waivers, the State is required to provide assurances that the health and safety of waiver participants will be protected, that there will be financial accountability for program funds, and that the projected per capita cost of the program will not exceed the costs that the Medicaid program would have incurred for the same individuals in the absence of a waiver. Waivers may be granted for an initial term of 3 years, and are renewable for 5 year periods unless the Secretary determines that the required assurances have not been met. Like section 1915(d) waivers, and unlike the earlier waiver programs, the new program is not discretionary. The Secretary cannot refuse to grant a waiver or waiver renewal to a State meeting the statutory requirements; any denial is subject to appeal.

IV. Other Waiver Authorities

Several statutes give the Secretary a broad authority to waive statutory requirements for Medicaid and other programs in order to conduct demonstration projects. For Medicaid purposes, the most important of these in recent years has been section 1115(a) of the Social Security Act, which allows waiver of any provision of Medicaid law for demonstrations "likely to assist in promoting the objectives" of the program. A State may be exempted from compliance with usual requirements or may receive Federal financial participation for expenditures not ordinarily eligible for Federal matching.[10] (There are restrictions on the use of demonstration waiver authorities to impose cost-sharing requirements on beneficiaries beyond those ordinarily permitted by law.)

Demonstration waivers differ from the other waiver programs described above in several respects. They are granted for research purposes, to test a program improvement or investigate an issue of interest to HCFA. Projects must usually include a formal research or experimental methodology and provide for an independent evaluation. Most projects run for a limited period, no more than 3 or 4 years, and are usually not renewable. Finally, the number and subject matter of the demonstrations are generally at the discretion of the Secretary.[11] A State does not qualify for a demonstration waiver, as it does for the 2175 and 2176 waivers, simply by meeting certain established conditions.

Projects conducted under the various demonstration authorities have played a major role in the development of Medicaid policy. Some past projects include early experiments with prospective payment for inpatient services and the first primary care case management programs. More recently, the entire medical assistance program for AFDC and SSI recipients in Arizona has been operated as an 1115(a) demonstration (see the discussion of the Arizona Health Care Cost Containment System, or AHCCCS, in Appendix F).[12] Table V–7 lists the section 1115(a) demonstration projects in operation as of August 1988.

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[10] Other authorities, rarely used for Medicaid projects, appear in section 402 of the Social Security Amendments of 1967 (Public Law 90–248) and section 222 of the Social Security Amendments of 1972 (Public Law 92–603).

[11] There is no specific limit on total expenditures for demonstration projects under the 1115(a) authority. Projects are funded through the general Medicaid appropriation, rather than through a distinct research appropriation.

[12] For a full summary of research and demonstration projects in progress see Health Care Financing Administration, Office of Research and Demonstrations, *Status Report: Research and Demonstrations in Health Care Financing.* Baltimore. 1988. [HCFA Pub. No. 03253]

Table V–7.—ACTIVE SECTION 1115 PROJECTS, AUGUST 1988

State	Project Name
Long-term care:	
Community-based care:	
California	Capitation Reimbursement for Comprehensive Long-Term Care (On Lok) SCAN Health Plan (S/HMO)
Minnesota	Ebenezer Society and Group Health Plan (S/HMO)
New Jersey	New Jersey Respite Care Pilot Program
New York	Elder-Care (S/HMO)
Texas	Modifications of the Texas System of Care for the Elderly
Institutional care:	
Massachusetts	Case-Managed Care for Nursing Home Patients: Design, Implementation, and Evaluation of a Prospective Case Mix System for Nursing Homes in Massachusetts
New York	New York State Integrated Quality Assurance System for Residential Health Care Facilities (NYQAS)
Texas	Texas Nursing Home Case Mix Demonstration Texas Long-Term Care Case Mix Reimbursement Project
Capitation:	
Arizona	Arizona Health Care Cost Containment System (AHCCCS)
Florida	Alternative Health Plan Project: Competitive Health Plans
Maryland	Program for Prepaid Managed Health Care
Minnesota	Medicaid Voucher Demonstration
New York	Health Care Plus
Welfare reform (incidental Medicaid components):	
New Jersey	Realizing Economic Achievement (REACH)
Wisconsin	Wisconsin Welfare Reform Demonstration
Other:	
Hawaii	Impact of Psychological Intervention on Health Care Utilization and Costs
New York	New York State Ambulatory Care Reimbursement Project

Source: Office of Research and Demonstrations, Health Care Financing Administration.

Finally, Congress has periodically mandated specific demonstration projects or special waivers in legislation. The following is a listing of the Medicaid or joint Medicare-Medicaid projects for which mandates have been enacted since 1984. Some of these projects are direct congressional initiatives. Others were initiated by the Secretary under 1115(a) or other authorities but were terminated or scheduled to expire; in these cases the congressional mandate was for an extension of the existing project.

Deficit Reduction Act of 1984, Public Law 98–369

Social health maintenance organizations (S/HMOs), which provide a continuum of health and social services to the elderly on a prepaid, capitated basis. (Extension)

[Continuing Appropriations, fiscal year 1986], Public Law 99–190

Municipal Health Services programs, which provide primary care in community-based facilities linked to municipal hospitals in 4 cities. (Extension)

Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99–272

The On Lok program in San Francisco, which provides health and social services on a prepaid basis to the frail elderly at risk of institutionalization. (Extension)

Access: Medicare (Monroe County, New York), which assesses the long-term care needs of Medicare-Medicaid beneficiaries and provides ongoing case management. (Extension)

Oregon's capitated ambulatory plans, which furnish physician and related services, but not inpatient care, on a prepaid basis. (Extension)

Texas' system of care for the elderly, which promotes community services in place of nursing home care. (Extension)

Wisconsin's Medicaid HMO program, which mandates HMO enrollment for beneficiaries in Madison and Milwaukee. (Extension)

Omnibus Budget Reconciliation Act of 1986, Public Law 99–509

Chronically mentally ill demonstration programs in several cities, which integrate medical care with housing and social services. (New program)

Frail elderly demonstration projects, which would replicate the On Lok program in other cities. (New program)

Massachusetts' Case Managed Medical Care program, which provides close medical monitoring of nursing home patients to reduce the need for inpatient hospital stays or outpatient visits. (Extension)

New Jersey's respite care pilot project, which provides support services for family caregivers to prevent institutionalization of the elderly or disabled. (New program)

Omnibus Budget Reconciliation Act of 1987, Public Law 100–203

New York's prenatal/maternity/newborn care pilot program, which would provide an alternative to conventional Medicaid coverage for pregnant women and newborns. (New program)

Arizona Health Care Cost Containment System (AHCCCS), which the State operates as an alternative to a Medicaid program. (Extension)

OBRA87 also authorizes waivers of certain Medicaid requirements to facilitate Washington State's Family Independence Project, an employment and training program for AFDC recipients.

CHAPTER VI. ADMINISTRATION [1]

SUMMARY

The Medicaid program is administered by State agencies under the general oversight of the Health Care Financing Administration, Department of Health and Human Services. States must designate a single administrative agency for program operations. The basic responsibilities of these agencies include: eligibility determination; provider certification; claims processing; review and inspection of facilities providing care, as well as the maintenance of the program's integrity and administration. This chapter provides information on State Medicaid agencies and on their performance of these basic administrative functions.

I. ADMINISTRATIVE STRUCTURE

A. Single State Agency

Each State must designate a single agency to operate its Medicaid program. This may be the welfare or social services department (25 States), the health department (4 States), or a combination health/social services department (15 States). In four States, the Medicaid agency is an independent entity. In two, it is part of a larger umbrella agency which is neither the welfare nor the health department.[2] Table VI–1 shows the type of agency used in each State. (A specific statutory exemption permits one State, Massachusetts, to use two separate Medicaid agencies, one responsible for the general program and the other for Medicaid coverage of the blind.) Six States delegate some of the administration of the program to local agencies, but the State maintains responsibility for overall policy determination.

Table VI–1.—MEDICAID ADMINISTRATION AND SSI ELIGIBILITY DETERMINATION

State	Medicaid agency	SSI determination
Alabama	Medicaid	1634
Alaska	Health/Social Services	State
Arkansas	Social Services	1634
California	Health [1]	1634
Colorado	Social Services	1634
Connecticut	Social Services	209(b)
Delaware	Health-Social Services	1634
District of Columbia	Health-Social Services	1634

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[1] This chapter was prepared by Mark Merlis and Richard Price.

[2] When the Medicaid program is only one of many operated by the State agency, the State must have an approved cost allocation plan to ensure that Federal funds for administrative costs are claimed only for Medicaid-related functions.

Table VI–1.—MEDICAID ADMINISTRATION AND SSI ELIGIBILITY DETERMINATION—Continued

State	Medicaid agency	SSI determination
Florida	Health-Social Services	1634
Georgia	Medicaid	1634
Hawaii	Social Services	209(b)
Idaho	Health-Social Services	State
Illinois	Social Services	209(b)
Indiana	Social Services	209(b)
Iowa	Social Services	1634
Kansas	Social Services	State
Kentucky	Health-Social Services	1634
Louisiana	Health-Social Services	1634
Maine	Health-Social Services	1634
Maryland	Health	1634
Massachusetts	Social Services	1634
Blind only	Commission for the Blind	
Michigan	Social Services	1634
Minnesota	Social Services [1]	209(b)
Mississippi	Medicaid	1634
Missouri	Social Services	209(b)
Montana	Social Services	1634
Nebraska	Social Services	209(b)
Nevada	Health-Social Services	State
New Hampshire	Health-Social Services	209(b)
New Jersey	Umbrella	1634
New Mexico	Social Services	1634
New York	Social Services [1]	1634
North Carolina	Health-Social Services [1]	209(b)
North Dakota	Social Services [1]	209(b)
Ohio	Social Services [1]	209(b)
Oklahoma	Social Services	209(b)
Oregon	Health-Social Services	State
Pennsylvania	Social Services	1634
Rhode Island	Social Services	1634
South Carolina	Umbrella	1634
South Dakota	Social Services	1634
Tennessee	Health	1634
Texas	Social Services	1634
Utah	Health	209(b)
Vermont	Social Services	1634
Virginia	Medicaid	209(b)
Washington	Health-Social Services	1634
West Virginia	Social Services	1634
Wisconsin	Health-Social Services	1634
Wyoming	Health-Social Services	1634

[1] Some administration (other than eligibility) delegated to counties.

Source: U.S. Department of Health and Human Services. Health Care Financing Administration. Analysis of State Medicaid Program Characteristics, 1986. Aug. 1987 table 59. p. 107. and American Hospital Association. American Hospital Association Guide to the Health Care Field, 1987 edition. 1987.

If the Medicaid agency is not the welfare or other agency managing the AFDC and SSI programs, then it must have an agreement with that agency for eligibility determination. Conversely, if the agency is not the State health department, it must have a cooperative agreement with the health department for advice on certification and quality standards and other purposes. In addition, the Medicaid agency must have agreements with the agencies administering the maternal and child health block grant and the State's vocational rehabilitation programs, to ensure maximum use of resources. There are other State agencies or programs that provide services to populations served by Medicaid and with which the Medicaid agency's functions potentially overlap, such as mental retardation and mental health agencies, offices on aging, crippled children's programs, and the WIC program (which provides nutritional services to women, infants, and children). Although many Medicaid agencies coordinate their activities with these other programs, coordination is not required and may not always occur.

Personnel of the Medicaid agency must be employed under a merit system; those in a decisionmaking capacity are subject to Federal ethics standards relating to activities of current and former employees. The agency must have a program to train and employ beneficiaries and other low-income persons in what the statute terms "subprofessional" jobs and to use volunteers.

Medicaid regulations require that each State establish a Medicaid advisory committee, including provider and beneficiary representatives, to review and make recommendations on Medicaid policy. (In some jurisdictions, Federal courts have invalidated substantive policy decisions made by a Medicaid agency without consulting the advisory committee.)

B. STATE PLAN

Each State's Medicaid program is operated in accordance with a State plan for medical assistance which describes the State's basic eligibility, coverage, reimbursement, and administrative policies. Many of the basic provisions in Medicaid law take the form of requirements for the content of State plans; the State plan thus constitutes the fundamental control mechanism for the program. The State plan must be amended periodically to reflect changes in Federal law or regulations or material changes in State law or policy. HCFA ordinarily notifies States when an amendment is needed because of a change in Federal rules. When the change is in State policy, a State plan amendment must be submitted by the end of the calendar quarter in which the policy change took effect. A State plan amendment is deemed approved unless the Secretary denies it within 90 days after its submission. A denial of a State plan amendment is subject to administrative appeal within DHHS and to review by Federal courts.

The Secretary may deny Federal Medicaid funding if the State issues payments in violation of its State plan or in accordance with a disapproved provision of the State plan. Technically, the Secretary could withhold all Federal funds in response to any violation. In practice, the Secretary withholds matching funds for State expenditures directly attributable to the violation. The denial of Federal funds may be retroactive to the date the State first implemented the policy change later disapproved. The State may request that payment of Federal matching funds for disputed Medicaid expenditures continue pending the outcome of an appeal before DHHS's Departmental Grant Appeals Board. If the State loses or withdraws its appeal, it is then liable for interest at a rate equal to the average of the bond equivalent of the weekly 90-day Treasury bill auction rates during the period the appeal was pending. Similar provisions apply when the State appeals other Federal penalties or funding reductions, as described later in this chapter.

C. Basic Program Operations

A Medicaid program pays claims for medically necessary covered services rendered by qualified providers to eligible beneficiaries. This basic program description defines the chief functions performed by the single State agency.

- It must determine which individuals are eligible to receive services.
- It must determine which providers are qualified to furnish those services.
- It must have a system for processing claims.
- It must maintain program control mechanisms, both to monitor its own performance and to ensure that the services it purchases are medically necessary and appropriate for the specific beneficiary receiving them.
- It must have systems for detecting fraud against the program or abuse of program benefits.

The remaining sections of this chapter provide an overview of State performance of each of these basic functions.

II. ELIGIBILITY DETERMINATION

A. Agencies Used

Many Medicaid beneficiaries qualify automatically as a result of their eligibility for cash assistance. Determination of Medicaid eligibility for persons receiving Aid to Families with Dependent Children (AFDC) must be performed by the same agency that determines AFDC eligibility. States have three options in determining Medicaid eligibility for persons receiving Supplemental Security Income (SSI). Table VI–1 shows the option elected by each State.

- In a State where SSI beneficiaries are automatically eligible for Medicaid, section 1634 of the Social Security Act allows the State to contract with the Social Security Administration (SSA) to perform Medicaid determinations for those beneficiaries. Social Security may also determine eligibility for the aged, blind, or disabled medically needy in SSI-related categories if the State's standards for these groups are essentially the same as those for SSI. States that choose to contract with SSA for these Medicaid determinations are sometimes called "1634 States." The State must pay SSA 50 percent of the costs attributable to Medicaid certification activities.
- A State may instead choose to conduct its own, separate Medicaid determinations, even though SSI beneficiaries are automatically eligible and the State could have contracted with SSA.
- A State that uses more restrictive standards for Medicaid eligibility than for SSI (so-called 209(b) States; see chapter II) must conduct its own Medicaid determinations.

For categories of beneficiaries other than AFDC and SSI (and the SSI-related medically needy in some States), Medicaid eligibility determination is a distinct process conducted by the Medicaid agency. Because the State must offer the opportunity to apply for benefits on a statewide basis, applications are generally taken at local welfare or social services offices. The Medicaid agency may have its own workers in those offices or may contract to have determinations done by social services workers. In some States applications may also be taken by on-site eligibility workers at hospitals or other facilities. These workers may be employed by the facilities themselves, although the actual determination of eligibility must be conducted by State or county workers.

B. APPLICATION PROCESS

Anyone must be permitted to complete an application. Persons who are potentially eligible in more than one category must be allowed to choose the category under which their application will be considered. (This requirement is meaningful in States which offer greater benefits to the categorically needy than to the medically needy.) States are required to complete the eligibility determination process and furnish assistance to eligible persons with "reasonable promptness." This has been defined in regulations as 60 days from the date of application for applicants claiming disability and 45 days for all other applicants. (As discussed in Chapter II, eligibility may be granted retroactively for up to 3 months before the date of application.)

The State must verify the information furnished on applications, largely through data exchange with other agencies. Each State is required to have an income and eligibility verification system for Medicaid and several other programs: AFDC, unemployment compensation, food stamps, and SSI. The State agencies responsible for these programs exchange benefit information, and can also obtain wage and income data from the Social Security Administration and the Internal Revenue Service. To facilitate these cross-checks, every applicant is now required to furnish a Social Security number; however, if the applicant has never opened a Social Security account, benefits may not be delayed while the applicant is obtaining a number. Effective September 30, 1988, the State must also have a system for direct collection of wage information from all employers (this requirement may be waived if the State has an adequate alternative). The information obtained through the verification system is used, not only to establish the applicant's eligibility, but also to assist in the collection of any child support payments due to the applicant.

For applicants who are not United States citizens, the State must also verify immigration status (assistance to illegal aliens may be furnished only for emergency care); 100 percent Federal funding is available for this activity. (See Chapter II for a discussion of eligibility for aliens, refugees, and illegal aliens.)

Establishment of eligibility for Medicaid is not permanent. The State must conduct periodic redeterminations of eligibility and must also take action between redeterminations if it learns of changes in a beneficiary's circumstances. The Secretary has established by regulation that redetermination must occur at least every 12 months; longer intervals are permissible for blind or disabled beneficiaries. Redetermination intervals for recipients of AFDC and SSI are set by the regulations for those programs; the interval is 6 months for AFDC and varies for different groups of SSI beneficiaries.

Applicants who are denied benefits must be given notice and an opportunity for a fair hearing. If the denial occurs during a redetermination and the applicant appeals on a timely basis, the State is required to continue benefits pending the outcome of the appeal, unless the sole issue in the appeal is one of Federal or State law or policy (as opposed, for example, to some fact about the particular beneficiary). If the State's position is sustained by the fair hearing decision, the State may recover from the beneficiary payments resulting from the benefit extension.

C. Presumptive Eligibility for Pregnant Women

The Omnibus Budget Reconciliation Act of 1986 (OBRA86, Public Law 99–509) gave States the option to establish "presumptive eligibility" for low-income pregnant women. The purpose of the provision is to ensure that prenatal care is not delayed because a woman does not have a Medicaid card during the time it takes for a State to process an ordinary Medicaid application. Certain providers of care may make an interim determination, on the basis of preliminary information, that a pregnant woman seeking treatment may be financially eligible for Medicaid benefits. Providers permitted to make this determination include individual practitioners, clinics participating in a number of Federally funded health-related programs or in a State perinatal care program, and Indian Health Service facilities. The provider must notify the Medicaid agency of the presumptive eligibility determination within 5 days, and must inform the woman that she is required to make a formal application for Medicaid within 14 days.

Once the provider has established tentative eligibility, the woman may receive ambulatory prenatal care for up to 45 days, or until the State has completed a full eligibility review, whichever is earlier. Even if the State should ultimately determine that the woman is not eligible, payment could still be made to the provider for services rendered during the presumptive eligibility period. However, if the woman fails to apply for Medicaid within 14 days after the initial determination, presumptive eligibility ceases.

As of January 1988, according to the National Governors' Association, the following 12 States had implemented the presumptive eligibility option: Arkansas, Florida, Maine, Maryland, Massachusetts, New Jersey, New York, North Carolina, Pennsylvania, Tennessee, Utah, and Wisconsin.

III. PROVIDER CERTIFICATION

States must have standards and procedures for determining the eligibility of providers of services to participate in the program. Federal law is specific about the standards and certification procedures for institutional providers, such as hospitals and nursing facilities. For other kinds of providers, such as physicians, pharmacies, and other practitioners, States follow their own laws on licensure and monitoring, with two exceptions: rural health clinics and clinical laboratories must comply with Medicare standards.

A. INSTITUTIONAL PROVIDERS

Before 1987, Medicaid programs used a single certification system for all institutional providers, including hospitals and nursing facilities, although there were some differences in the standards applicable to different types of providers. Public Law 100-203, The Omnibus Budget Reconciliation Act of 1987 (OBRA87) establishes a new set of standards for nursing facilities participating in Medicare or Medicaid, a new system for monitoring compliance with those standards, and a new set of sanctions for noncompliant facilities. The new rules are being phased in over the period December 22, 1987, through October 1, 1991; different requirements take effect at different times. Table VI-2 shows the implementation timetable for the new system.

Table VI-2.—EFFECTIVE DATES FOR IMPLEMENTATION OF MEDICAID NURSING HOME REFORM PROVISIONS (PUBLIC LAW 100-203 AS REVISED BY PUBLIC LAW 100-360)

Effective date	Nursing home provision(s)
January 1, 1988	HHS alternate enforcement remedies in effect.
March 1, 1988	HHS must develop standards for facility administrators.
April 1, 1988	States must develop residents' rights notice.
July 1, 1988	1. HHS must issue regulations pursuant to section 21(b) of 1977 Medicare-Medicaid Anti-Fraud and Abuse Amendments to define costs which may be charged to residents' personal funds.
	2. States must identify facility services that are covered under State plan.
September 1, 1988	HHS must establish minimum standards for nurse aide training programs.
October 1, 1988	1. HHS must establish minimum criteria for State preadmission/annual review programs (including appeals process) for mentally ill/mentally retarded individuals.
	2. HHS must develop criteria and procedures for monitoring States' performance in granting waivers of nurse staffing requirements
	3. HHS must establish guidelines for State appeals process for facility transfers.
	4. HHS must provide guidance to States in establishing alternate enforcement mechanisms.
January 1, 1989	1. States must specify nurse aide training programs to be used by facilities.
	2. States must have preadmission screening program in place for new resident applicants who are mentally ill/mentally retarded to determine appropriate placement.
	3. States must have appeals process in place for those adversely affected by preadmission/annual resident review programs for mentally ill/mentally retarded individuals.
	4. States must establish nurse aide registries.
	5. HHS must specify minimum data set of core elements for use by facilities in conducting resident assessments.
April 1, 1989	State/HHS agreements for disposition of mentally ill/mentally retarded residents must be in place to meet annual review requirements.
July 1, 1989	States must implement HHS standards for facility administrators.
October 1, 1989	1. States must provide appeals process for facility transfers; facilities must provide notice of such process to residents.
	2. States must establish alternate enforcement remedies in law or regulation.
January 1, 1990	1. Nurse aides must complete a training program and be competent to provide services.
	2. HHS must establish standard/extended survey protocols and minimum qualifications for surveyors.
	3. States must review and reapprove nurse aide training programs in use.
April 1, 1990	1. States must submit first State plan amendment to HHS specifying payment adjustments for facility services.
	2. States must begin annual review of mentally ill/mentally retarded residents for appropriateness of continued stay.
	3. Initial State annual review of mentally ill/mentally retarded residents for appropriateness of continued stay must be completed.

Table VI–2.—EFFECTIVE DATES FOR IMPLEMENTATION OF MEDICAID NURSING HOME REFORM PROVISIONS (PUBLIC LAW 100–203 AS REVISED BY PUBLIC LAW 100–360)—Continued

Effective date		Nursing home provision(s)
	4.	For mentally ill/mentally retarded residents who are (i) residing in facility 30 months or more; and (ii) not in need of facility services but in need of active treatment, States must give choice of remaining in facility or transferring to appropriate setting and must provide active treatment.
	5.	For same population specified in (4) but who are residing in facility less than 30 months, States must discharge and provide active treatment.
	6.	For mentally ill/mentally retarded residents not in need of facility services or active treatment, States must discharge.
	7.	HHS must designate resident assessment instrument(s).
July 1, 1990		States must specify resident assessment instrument(s) approved by HHS.
October 1, 1990	1.	Distinction between SNFs and ICFs (including payment differential) is eliminated. Except as specified at other dates, facility requirements and survey and certification process take effect.
	2.	HHS must have reviewed first State plan amendments specifying payment adjustments for facility services.
	3.	Assessments begin for all new residents.
	4.	Facilities must provide (i) 24-hour L.P.N. services; and (ii) 8-consecutive hour R.N. services 7 days a week. (State waivers available for either requirement upon adequate demonstration.)
October 1, 1991		All residents must be assessed at least once.
January 1, 1993	1.	HHS must evaluate and report to Congress on resident assessment process.
	2.	HHS must report to Congress on implementation of nurse staffing requirements and use of State waivers.

Source: Prepared by Congressional Research Service.

The existing system remains in effect for hospitals and intermediate care facilities for the mentally retarded (ICFs/MR). The following discussion describes the old system, which covered these facilities as well as nursing homes, and the new system for nursing homes. The old and new requirements are compared in three areas: survey and certification, standards, and remedial action.

1. SURVEY AND CERTIFICATION

a. *Current system.* For certification of institutional providers, the Medicaid agency is required to rely on the same State survey agency used by the Secretary to review Medicare providers. (For certification of hospitals, both Medicare and Medicaid may rely on findings of independent assessors, such as the Joint Commission on Accreditation of Health Care Organizations.) Medicaid follows the Medicare determination for hospitals, skilled nursing facilities (SNFs), and other facilities operated by the Indian Health Service.[3] The Secretary notifies the Medicaid agency of Medicare certification and decertification actions, and the State is obliged to conform.

Intermediate care facilities (ICFs) and intermediate care facilities for the mentally retarded (ICFs/MR) are not covered under Medicare. The Medicaid agency therefore deals directly with the State survey agency for these providers.[4] All facilities must be inspected and recertified every 12 months; findings of the survey agency must be made available to the public. The Secretary has the authority to "look behind" the findings of the State survey agency for all types of facilities; that is, the Secretary may make an independent determination that the facility does not meet Federal standards.

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[3] Facilities certified by the First Church of Christ, Scientist, Boston, are not subject to State or Federal certification requirements.

[4] In some instances, the Medicaid agency and the State survey agency are within the same department. In addition, some of the facilities reviewed by the survey agency, such as public hospitals and ICFs–MR, may be State operated.

In addition to certifying the facilities themselves, States are required to have a system for licensing nursing home administrators. The system must provide for examinations and investigations, ongoing compliance monitoring, and complaint investigation and resolution.

b. *New System.* OBRA87 restructures the survey and certification process that applies to nursing facilities participating in Medicaid. The new survey and certification procedures take effect October 1, 1990. At that time, the Secretary of HHS will become responsible for certifying all State-owned nursing facilities and States will be responsible for certifying all other facilities, subject to Federal "look-behind" reviews.

Under the new process, all nursing facilities participating in Medicaid will be subject to an unannounced standard survey; facilities found deficient in the standard survey will then be subject to more extended review. The two-tier process may thus focus resources on noncompliant facilities.

Each facility's standard survey must be conducted not later than 15 months after the date of the previous standard survey. The average interval between standard surveys in a State could not exceed 12 months. Standard surveys will include, for a case-mix stratified sample of residents, a review of the quality of care furnished by the facility, residents' written plans of care and assessments, and the facility's compliance with requirements pertaining to residents' rights. These requirements are intended to assure that the survey process be resident-centered and outcome-oriented, and not be limited to observations of the facility, its policies, and procedures.

A standard survey (or an abbreviated standard survey) may also be conducted within 2 months of any change of ownership, administration, or management of a nursing facility, or a change in its director of nursing, in order to determine whether the change has resulted in any decline in the quality of care furnished by the facility.

Each nursing facility found under a standard survey to have provided substandard care will be subject to an extended survey. This survey must be conducted immediately after the standard survey and must identify the policies and procedures that resulted in substandard care. The extended survey must also determine compliance with every requirement for participation in Medicaid, and must include a review of staffing, in-service training, and an expanded sample of residents' assessments. The new requirements for surveys also specify that any other facility, besides those found to be providing substandard care, can be subject to an extended survey.

Federal matching rates for State costs of survey and certification activities will be 90 percent for fiscal year 1991, 85 percent for fiscal year 1992, 80 percent for fiscal year 1993, and 75 percent for fiscal year 1994 and for fiscal years thereafter.

Under the new requirements, the Secretary of HHS must conduct onsite validation or "look-behind" surveys of at least 5 percent of the facilities surveyed by the State each year in order to determine the adequacy of State survey activities. If after these validation surveys the Secretary finds State performance to be inadequate, the Secretary must reduce matching payments made to the State for survey and certification activities. The new law specifies that this reduction be equal to 33 percent of the ratio of the total number of residents in noncompliant facilities to the total number of residents in facilities surveyed by the Secretary in validation surveys.

2. STANDARDS

a. *Current system.* Medicaid standards for hospitals and SNFs are identical to those used for Medicare. Certification of ICFs follows the State's own laws for nursing home licensure, subject to certain Federal guidelines. All types of facilities must meet standards relating to:

- Professional supervision and staffing levels;
- State licensure, where applicable, and conformance with State and Federal health and safety standards;
- Utilization review programs, as described later in this chapter; and
- Management and budgetary practices.

Nursing facilities must comply with additional standards regarding arrangements for ancillary services and for transfer of patients, protection of patients' rights, control of medications, and handling of patients' personal funds. ICFs/MR and psychiatric hospitals treating beneficiaries under age 21 are required to furnish active treatment, in accordance with an individual plan of care, intended to improve the beneficiary's condition and prevent further regression.

b. *New System.* Effective October 1, 1990, OBRA87 eliminates the current law distinction between SNFs and ICFs participating in Medicaid and creates a "nursing facility" benefit under the program, with a single set of requirements that nursing facilities must meet in order to participate in Medicaid. OBRA87 establishes in Medicaid law detailed specifications as to the scope of services a nursing facility must provide, levels of staffing in the facility and qualifications of staff, assessment of each resident's functional capacity, residents' rights, and the physical environment of the facility, among others.

Effective January 1, 1989, the law also requires that nursing facilities not admit any individual who is mentally ill or mentally retarded unless the State mental health authority or State mental retardation authority, respectively, has determined that the individual requires the level of services provided by the facility.

3. REMEDIAL AND ENFORCEMENT ACTION

Under the timetable for implementation of the OBRA87 nursing home changes, new options for remedial action in the case of provider deficiencies are available to the Secretary as of enactment.

However, States may continue to operate under the existing rules on remedial action until October 1, 1989.

a. *Current System.* If a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF/MR) no longer substantially meets the requirements for participation, the State has two possible courses of action. First, it may terminate the facility's certification. Second, if the deficiencies do not immediately jeopardize the health or safety of patients, it may, after notice to the facility and the public, deny Medicaid payment for any new patients admitted after a notice of noncompliance, while continuing reimbursement for existing patients. The facility may then be given a limited period to correct the problems. If the facility is still not in substantial compliance, or is not found to have made a good faith effort to achieve compliance, by the end of the eleventh month following the initial finding of noncompliance, certification must then be terminated. The facility must be given a reasonable opportunity to correct any problems after an initial notice of noncompliance, and must be given notice and an opportunity for a hearing before decertification or other sanctions take effect.

A third course of action is available when deficiencies are found at an ICF/MR. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, Public Law 99–272) provides a choice between correction or reduction plans for facilities where the Secretary finds deficiencies which, while substantial, do not pose an immediate threat to residents. The State may submit a plan of correction for all observed deficiencies, including a timetable for rectifying all staffing and physical plant problems within 6 months. Or it may submit a 3-year plan for reduction of the total patient load at the facility to the point at which it will be possible to bring the facility into compliance for its remaining patients, by closing deficient parts of the facility or improving staff-patient ratios. Reduction would be accomplished by shifting patients to home and community-based treatment. This option expires in April 1989.

b. *New System.* OBRA87 expands the remedies available to States and the Secretary for sanctioning noncompliant nursing facilities. If the State finds after a survey that a facility is not in compliance with the requirements for participation, and that its deficiencies immediately jeopardize the health or safety of its residents, the State must either (1) take immediate action to remove the jeopardy and correct the deficiencies through the appointment of temporary management, or (2) terminate the facility's participation in Medicaid. In addition, the State may also impose other specified remedies that include denial of payment for new admissions; civil money penalties; or, in the case of an emergency, closing of the facility or transfer of residents, or both. Similar authority is provided to the Secretary.

If the State finds that a facility is not in compliance and that its deficiencies do not immediately jeopardize the health or safety of its residents, then the State may terminate the facility's participation in Medicaid and/or impose other remedies short of termination.[5] These include denial of payment for new admissions; civil money penalties for each day of noncompliance; temporary management; and, in the case of an emergency, closing of the facility or transfer of residents, or both. Similar authority is provided to the Secretary. The new law also specifies procedures to be followed where the State and Secretary do not agree on findings of noncompliance.

If a facility has not complied with the law's requirements within 3 months after a finding of noncompliance, the State must deny payment for new admissions. For facilities found on three consecutive standard surveys to have provided substandard care, States must deny payment for new admissions and monitor the facility until it has demonstrated that it is in compliance and will remain in compliance.[6] In the case of facilities that are taking steps to eliminate deficiencies according to a plan of correction submitted by the State and approved by the Secretary, the Secretary may continue Federal matching payments for not longer than 6 months.

In addition to establishing new sanction authority for noncompliance, OBRA87 also authorizes States to establish a program to reward, through public recognition or incentive payments, or both, nursing facilities that provide the highest quality care to residents who are Medicaid beneficiaries. These programs would be eligible for Federal matching payments at the 50 percent rate for general administration costs, as opposed to the higher matching rate for services applicable in many States (see Chapter VII).

B. NON-INSTITUTIONAL PROVIDERS

As noted earlier, States follow their own procedures for certifying individual practitioners and other noninstitutional providers, such as pharmacies or clinics. Ordinarily the Medicaid agency relies on the findings of the applicable licensing agency or board. However, the Medicaid agency is authorized to conduct its own reviews of the quality of practitioners and may exclude providers who furnish excessive or inadequate services (see the discussion of exclusions in section VI.B., below). The Medicaid program may impose additional standards of its own or develop procedures for certifying special types of providers not traditionally recognized under State licensing law (for example, family planning clinics).

There have been concerns that some providers who lose their licenses or face other disciplinary action may take up practice in other States or may continue to practice as employees of hospitals or other entities. The Medicare and Medicaid Patient and Program Protection Act of 1987 (Public Law 100–93) requires States to report to the Secretary any adverse action by a licensing authority, including revocation or suspension of a license, reprimand, censure, or probation. The State must also report cases in which a provider surrenders a license voluntarily or leaves the State while an adverse action is pending. The Secretary may then disseminate this information to agencies administering Federal health programs (including Medicare intermediaries and carriers); other States' licensing agencies, health agencies and Medicaid fraud units; hospitals or other providers that might consider the practitioner for employment or staff appointment; and other parties, such as peer review organizations, the United States Attorney General and other law enforcement officials, and the General Accounting Office. The Secretary is required to maintain confidentiality, except for the disclosures authorized by law.

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[5] The new intermediate sanctions address a concern that, if the only penalty available for a violation is termination, deficiencies not serious enough to warrant termination might not be addressed. This problem was pointed out by the General Accounting Office (GAO) in a 1987 report. U.S. Congress. General Accounting Office. Medicare and Medicaid: Stronger Enforcement of Nursing Home Requirements Needed. Washington. July 1987. [GAO/HRD-87-113]

[6] The GAO report cited above noted that, under the previous rules, a facility could correct a deficiency temporarily, be found compliant in a recertification review, and then resume the violation. So long as it corrected the problem again each time it was uncovered, the facility could continue participating indefinitely.

IV. CLAIMS PROCESSING

Most Medicaid payments must be issued directly to the provider furnishing the service, not to the beneficiary.[7] Providers are prohibited from using "factors." Factors are collection agents to whom providers sell their accounts receivable or who are reimbursed on the basis of the amounts recovered. Providers may use collection agents who are paid on a fixed fee basis or may assign their billing rights to their employer or to the facility in which they practice.

States are required to pay 90 percent of "clean" claims from practitioners within 30 days, and 99 percent within 60 days. A clean claim is one which has been correctly completed and which has all the information required for payment, such as a valid beneficiary number and a full description of the services rendered. The prompt payment requirement may be waived by the Secretary for good cause. (Note that the requirement applies only to practitioner claims. Payment to institutional providers may take longer.)

Before issuing payment, the State must subtract from the amount due to the provider certain amounts which the State or Federal government is entitled to recover. These include prior overpayments under either Medicare or Medicaid, amounts due from the provider under Internal Revenue Service or other garnishment proceedings, and overcharges subject to recovery under the third party liability rules described in Chapter IV. The State's claim for Federal financial participation must be adjusted to reflect these recoveries. In the case of Medicaid overpayments, the Secretary may reduce funding to the State after 60 days even if the State has not actually recovered the funds (unless circumstances, such as a provider's bankruptcy, make recovery impossible).

Many States use outside fiscal agents to process claims. The agent may be used for all claim types or only for specific services, such as pharmacy. Table VI-3 shows the States using fiscal agents and the services for which the agent is used. The fiscal agent may be a local organization, such as a Blue Cross/Blue Shield plan; there are also several national firms which sell claims processing services to States. In States that use fiscal agents it is common for the agent to operate the State's Medicaid Management Information System or MMIS (see below).

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[7] Federal Medicaid law provides that beneficiaries who are not receiving cash assistance may be reimbursed directly for services furnished by physicians or dentists. It is not known whether any State actually uses this option.

Table VI–3.—MEDICAID CLAIMS PROCESSING STATUS AS OF MARCH 31, 1986

State	Type of claim				
	Inpatient hospital	Physician services	Dental services	Prescription drugs	Long-term care facilities
Alabama	F	F	F	F	F
Alaska	F	F	F	F	F
Arkansas	F	F	F	F	S
California	F	F	FS	F	F
Colorado	F	F	F	F	F
Connecticut	F	F	F	F	F
Delaware	F	F	F	F	S
District of Columbia	F	F	F	F	F
Florida	F	F	F	F	F
Georgia	F	F	F	F	F
Hawaii	F	F	F	F	F
Idaho	FS	FS	FS	FS	FS
Illinois	S	S	S	S	S
Indiana	H	H	H	H	F
Iowa	F	F	F	F	FS
Kansas	F	F	F	F	F
Kentucky	F	F	F	F	F
Louisiana	F	F	F	F	F
Maine	S	S	S	S	S
Maryland	S	S	S	S	S
Massachusetts	F	F	F	F	F
Michigan	S	S	S	S	S
Minnesota	S	S	S	S	S
Mississippi	F	F	F	F	F
Missouri	F	F	F	F	F
Montana	F	F	F	F	F
Nebraska	S	S	S	S	S
Nevada	FS	FS	FS	FS	FS
New Hampshire	F	F	F	F	F
New Jersey	F	F	F	F	S
New Mexico	F	F	F	F	F
New York	F	F	F	F	F
North Carolina	F	F	F	F	F
North Dakota	S	S	S	S	S
Ohio	S	S	S	S	S
Oklahoma	S	S	S	S	S
Oregon	S	S	S	S	S
Pennsylvania	S	S	S	S	S
Rhode Island	S	S	S	S	S
South Carolina	S	S	S	S	S
South Dakota	S	S	S	S	S
Tennessee	F	F	F	F	F
Texas	H	H	S	S	S
Utah	S	S	S	S	S
Vermont	F	F	F	F	F
Virginia	F	F	F	F	F
Washington	FS	FS	FS	FS	FS
West Virginia	F	F	F	F	S
Wisconsin	F	F	F	F	F
Wyoming	S	S	F	S	S

F—Fiscal agent processes claims
S—State agency processes claims
FS—Both State and Fiscal agent process claims
H—Health insuring organization processes claims

Source: U.S. Department of Health and Human Services. Health Care Financing Administration. Analysis of State Medicaid Program Characteristics, 1986, Aug. 1987. p. 109, and unpublished HCFA reports.

Three States have entered into arrangements under which the fiscal agent assumes direct financial responsibility for payment of services. The State issues a fixed monthly payment to the agent, known as a "health insuring organization" or HIO, for each eligible beneficiary. The HIO uses the funds to reimburse providers, and may retain some of the savings—or suffer a loss—if amounts paid to providers differ from the total payment received from the State. These arrangements are not the same as the State contracts with health maintenance organizations or prepaid health plans described in chapter V. Although the HIO is paid a fixed amount and is at risk for costs in excess of that amount, it does not directly provide or arrange care, and beneficiaries are not required to use a specific group of providers affiliated with the organization. The HIO pays for services rendered by any qualified Medicaid provider. It may control costs through preauthorization systems or intensified claim review, but does not generally engage in the activities known as "managed care" (see Appendix F). In Texas and Indiana, an HIO arrangement is used for all beneficiaries in the State. In California, an HIO serves beneficiaries only in limited geographic areas.[8]

V. PROGRAM CONTROLS

A Medicaid agency must engage in a variety of activities to ensure that the program is properly administered:

- It must monitor its own administrative performance, subject to Federal oversight, through a quality control system.
- It must collect information on program utilization and expenditures and complete reports required by the Secretary. In most States, these functions must be performed by a federally certified Medicaid Management Information System (MMIS).
- It must have systems for reviewing the adequacy and appropriateness of services furnished to beneficiaries.

A. Medicaid Quality Control

Medicaid, like some other Federally funded, State administered programs, has a "quality control" system, under which each State monitors certain aspects of its own administrative performance. Under Medicaid, the chief focus of the system is identification of eligibility errors that have resulted in improper Federal payments. All States are required to review the accuracy of eligibility determinations. A State without a certified MMIS must also review the accuracy of its claims processing system. Changes in regulations in January 1988 have eliminated a requirement that all States review a third area, the extent to which the State enforces third party payment requirements.

For each area of activity to be studied, the State selects a monthly sample of cases for review, which may involve conducting field interviews with beneficiaries or obtaining information from other sources. A portion of the sample is also reviewed directly by HCFA.

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[8] In recent years, some States have entered into contracts with another kind of organization, also known as an HIO, which more closely resembles a health maintenance organization. These very different arrangements are described in Appendix F.

HCFA may review an entire sample of its own if a State has failed to comply with review requirements.

In eligibility reviews, the State identifies cases in the sample for which an error has resulted in payments for services to a beneficiary who was not eligible or whose liability under spenddown has been underestimated. In claims processing reviews, the State identifies errors such as payments for noncovered services or duplicate payments for services previously billed. For both types of review, the State then computes an error rate for the sample, equal to:

$$\frac{\text{Medicaid dollars spent as a result of State error}}{\text{Medicaid dollars spent for the entire sample}}$$

OBRA87 provides that certain technical errors, such as failure to obtain an applicant's Social Security number, are not to be counted in the error rate if the errors did not result in payments higher than would otherwise have been made (this provision expires December 31, 1988). In addition, SSI errors in States where the Social Security Administration determines SSI eligibility are not counted.

The error rate found in the sample is assumed to be the error rate for all the State's Medicaid payments. If this rate is greater than 3 percent, then Federal payments for Medicaid services may be reduced by a percentage equal to the excess error rate. For example, if a State's error rate during a quarter is 7 percent, its excess error rate is 4 percent, and Federal payments for services in that quarter will be 96 percent of what would otherwise have been paid. Again, the reduction does not apply to payments for SSI beneficiaries in States where Social Security determines SSI eligibility, nor to payments for State Medicaid administration.

The payment reduction may be made in two ways. First, there may be interim withholding from the quarterly Federal advance payments to a State, reflecting a projected error rate based on prior periods' reviews. The State may persuade HCFA to modify its projections in advance, and some of the withheld sums will be returned to the State if subsequent reviews indicate that the real error rate was below the projected rate. Second, there may be a retrospective disallowance computed on the basis of the final error rate for the year. The State may request a waiver of the disallowance by showing that a good faith effort was made to reduce the error rate. If the waiver is not granted, it may appeal the disallowance through the DHHS administrative hearing process.

Except for three small disallowances in fiscal year 1983 which were not appealed, every disallowance from fiscal year 1981 on for which a good-faith waiver was not granted has been appealed by the State involved. Every appeal was still pending as of January 1988. In every case from fiscal year 1982 on, the State has retained the amount in dispute; if the disallowances are ultimately sustained the States will owe interest on the retained amounts.

Three recent actions by Congress have affected the functioning of the Medicaid quality control system. First, COBRA provided for a study of the methodologies used in the AFDC and Medicaid quality control systems. (The study, performed by the National Academy of

Sciences, was submitted to Congress in 1988.) The Act established a moratorium on AFDC penalties pending completion of the study, but did not apply the moratorium to Medicaid penalties. OBRA87 does provide for a moratorium, until July 1, 1988, on the actual collection of Medicaid penalties, but does not prohibit subsequent collection of penalties for State errors occurring during the moratorium period.

Finally, the Medicare Catastrophic Coverage Act of 1988 (Public Law 100–360) has modified, retroactively to 1982, provisions that required States' methodologies for determining eligibility for medically needy beneficiaries to conform to the methodology for determining eligibility for the related categorically needy group (i.e., SSI for the aged, blind, and disabled, and AFDC for families with children). Prior to this change, the law required that the methodologies be the "same"; now the medically needy methodology must simply be "no more restrictive" than the categorically needy methodology. (The 1988 change followed a moratorium that limited the Secretary's authority to impose penalties for State violations of the previous rule during the period October 1981 through February 1989.) A significant portion of the eligibility errors counted against States from 1982 on have related to the rules affected by this change. HCFA will therefore be obligated to recompute and reduce many of the error rates and disallowances for the affected years.[9]

B. Medicaid Management Information System.

In the early 1970s, HCFA's predecessor agency (the Social and Rehabilitation Service) began development of a model data processing system for State Medicaid agencies, the Medicaid Management Information System or MMIS. The model MMIS included basic systems for maintaining information on beneficiaries and providers and for processing claims. In addition it included systems intended to improve program management, including a system for generating budgetary and statistical reports and a Surveillance and Utilization Review subsystem (S/URS) to help identify abusive or fraudulent practices by beneficiaries and providers. The Social Security Amendments of 1972 (Public Law 92–603) provided that States could receive 90 percent Federal financial participation in the costs of developing an MMIS or comparable system, and 75 percent funding for ongoing operations of the system.

The Mental Health Systems Act of 1980 (Public Law 96–398) required all States to have an MMIS meeting Federal standards by September 30, 1982 (later changed to 1985), or face reductions in Federal financial participation in program administrative costs. Exceptions were permitted for States with a population of less than 1,000,000 and with total Medicaid expenditures of less than $100 million in fiscal year 1976, as well as for territories. As of January 1988, 5 States—Alaska, Delaware, Nevada, Rhode Island, and Wyoming—were exempt from MMIS requirements. All the other States had passed their initial MMIS certification review.

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[9] Pending completion of these recomputations, no reliable error rate or disallowance figures were available for inclusion in this report.

Continued State compliance with the MMIS requirements is monitored by HCFA through a process called Systems Performance Review, or SPR. SPR considers, not only the performance of the computer system itself, but also the extent to which States use the system in program management. A State which fails the annual SPR may be subjected to financial penalties or may have the certification of its MMIS revoked.

C. UTILIZATION REVIEW AND INSPECTION OF CARE

Medicaid law and regulations contain extensive requirements for review of the appropriateness and adequacy of the services furnished by general hospitals, mental hospitals, and nursing facilities. Activities conducted by the facilities themselves include initial and periodic recertification of each patient's need for care, development of plans for the care of each patient, and operation of an approved utilization review (UR) program. The State must also provide for external reviews, known as inspections of care. This requirement is deemed met if the State contracts with a utilization and quality peer review organization (PRO), one of the entities used by the Secretary to conduct Medicare reviews. A description of each of these review activities follows.

The nursing home changes included in OBRA87 will eliminate recertification of the need for care and the State inspection of care process for residents of nursing homes. These will be replaced by the new resident- oriented survey process described earlier in this chapter (the requirements will remain in effect for hospitals and ICFs/MR).

1. CERTIFICATION AND PLANS OF CARE

For all types of institutional care, a physician must certify the patient's need for the level of care furnished by the institution at the time of admission, or at the time the patient qualifies for Medicaid benefits, if this occurs after admission. For care in nursing facilities and psychiatric facilities, the initial certification must be reviewed by the Medicaid agency and must include a social and psychiatric evaluation. In the case of care in ICFs, if the initial evaluation concludes that care at the ICF level is necessary only because alternative services are temporarily unavailable, the facility must attempt to arrange the services which would allow discharge.

The need for institutional care must be periodically recertified by a physician, at intervals which vary according to the type of facility. For hospital inpatient care, recertification is required every 60 days. Recertification for SNF services is required every 30 days in the first 3 months of the stay and every 60 days thereafter. For ICF/MR services, recertification is required every 12 months, while for other ICF services reviews must be scheduled at the following intervals from the date of admission: 60 days, 180 days, 12 months, 18 months, 24 months, and every 12 months thereafter.

Recertification in SNFs and ICFs (other than ICFs/MR) will no longer be required after the new nursing home survey and certification process takes effect in October 1990. (Annual reviews of mentally ill and mentally retarded residents will be required.)

Until then, recertifications may be performed by a nurse practitioner or clinical nurse in association with a physician.

In addition to certifying the need for institutional services, the attending physician—or in some cases a multidisciplinary team—must develop a written plan of care for each patient. The plan must specify the treatment and other services to be furnished to the patient and include plans for continuing care and, if appropriate, for discharge. Like the certification, the plan of care must be reviewed by the physician or team at specified intervals.

2. UTILIZATION REVIEW

Hospitals and nursing facilities are required to have plans for ongoing internal utilization review (UR), including periodic assessments of the care required by each patient and general reviews, known as medical care evaluation studies, to identify patterns of care and problem areas and to recommend changes. (The general studies are not required at ICFs.)

These activities are carried on by a UR committee at each institution, made up of the facility's own attending physicians and outside professionals. For facilities which are also Medicare providers, the UR plans and committees must be the same as those used for Medicare. This requirement may be waived if the State shows that it has an equally effective system of its own.

The UR committee must periodically reassess each patient's need to continue receiving care from the facility. These assessments are distinct from the physician recertifications; the physician certifying the need for continued care may not participate in the independent assessment of the UR committee, and the intervals between reviews are different. For hospital inpatient services, the periods between reassessments vary according to established norms for different patient conditions. In mental hospitals and SNFs, the first review is due 30 days after admission and every 90 days thereafter. For ICFs and ICFs/MR, 6 month intervals are permitted. The deadlines for reassessment may be waived for facilities in rural areas, where it may not be possible to convene the UR committee often enough to meet the deadlines.

3. INSPECTION OF CARE

The Medicaid agency is required to conduct annual inspections of care at every inpatient facility in the State and every State-owned facility regardless of location. An inspection team reviews the records of every beneficiary who has received 60 or more days of care (90 for mental hospitals) to assure that services are adequate and to determine whether alternatives to institutional care are appropriate.

States may face financial penalties for failure to meet the inspection of care requirements. HCFA performs independent reviews for a sample of facilities. States are required to be in compliance for 98 percent of all facilities, and for all facilities with 200 or more beds. A facility is deemed to be noncompliant if a single beneficiary at the facility has not been reviewed by the end of the quarter 1 year after the previous review. HCFA establishes a noncompliance ratio by dividing the number of beneficiaries in noncompliant facilities by the total number of beneficiaries receiving the same level of care (hospital, SNF, ICF, ICF/MR). Federal funding for all services at that level of care during a quarter may be reduced by an amount equal to one-third times the noncompliance ratio established for the quarter.

Again, these provisions will cease to apply to nursing facility services after October 1990.

VI. PROGRAM INTEGRITY

Program integrity activities are those intended to detect, investigate, and sanction fraud against or abuse of the Medicaid program by providers or beneficiaries. Fraud consists of obtaining payments or other benefits to which the provider or beneficiary is not entitled, through misrepresentation or withholding of relevant information. Abuse of the program consists of activities which are not fraudulent but which result in inappropriate expenditures of program funds. A physician who submits a claim for an operation that was never performed has committed fraud; if the operation was actually performed but was clearly unnecessary, the provider has committed abuse. Similarly, a beneficiary who is certified as eligible for Medicaid because he or she knowingly failed to report all income has committed fraud. A beneficiary who visits multiple physicians in order to obtain duplicate prescriptions for a single drug has committed abuse.

A. Detection of Fraud and Abuse

States are required to have systems for identifying and investigating cases of potential fraud and abuse. They may rely on the Surveillance and Utilization Review subsystem (S/URS) of the MMIS, which processes data on paid claims and selects exceptional providers or beneficiaries according to criteria established by the State. Cases may also be developed through other means, such as financial audits of cost-reimbursed providers, information obtained during the Medicaid quality control process, referrals from licensing and other agencies, or direct calls from the public.

Cases of apparent abuse are generally handled within the Medicaid agency. The agency may take steps to reeducate the provider or beneficiary involved or may impose one of the sanctions described below. Cases of fraud, on the other hand, are usually referred, after preliminary investigation, to an outside prosecutorial authority.

The Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95–142, 1977) provided special Federal funding levels for State Medicaid fraud control units (SMFCUs). An SMFCU must be independent of the single State agency operating the Medicaid program. It must be part of the State Attorney General's office or coordinate with that office, and must either have statewide prosecutorial authority or the ability to refer to local prosecutors. The SMFCU investigates State law fraud violations (Federal violations are prosecuted by United States Attorneys), and also reviews and prosecutes cases involving neglect or abuse of beneficiaries in nursing homes and other facilities.

Federal matching is available at 90 percent for the first 3 years of an SMFCU's operations and at 75 percent thereafter. However, funding is limited to the higher of $125,000 or one quarter of 1 percent of total State and Federal Medicaid expenditures for the State. SMFCUs operated in 38 States in fiscal year 1987 and received a total of $44.1 million in Federal matching funds. During the year ended June 30, 1987, SMFCUs reported 453 convictions and almost $8.5 million in fines, overpayments, and restitutions.[10]

In a State without an SMFCU, the Medicaid agency must maintain its own fraud investigation capacity and refer cases of suspected fraud to appropriate State or Federal law enforcement agencies.

Federal agencies may act on their own to pursue Medicaid fraud or abuse cases. The Secretary of DHHS, acting through the Office of the Inspector General, may investigate cases of provider fraud or abuse and may impose civil monetary penalties or exclusion from program participation (see below). U.S. Attorneys may prosecute criminal and civil cases of fraud against the Medicaid program.

B. Sanctions

Four basic kinds of sanctions may be used against providers and beneficiaries found to have violated program requirements, depending on the nature and severity of the offense. Individual providers and beneficiaries, or the owners or managers of institutional providers, may be subject to criminal prosecution. They may be liable for civil monetary penalties. They may be excluded from program participation, temporarily or permanently. Finally, a temporary restriction on the use of Medicaid services, known as "lock-in," may be imposed on beneficiaries found to have used services inappropriately.

Note that the sanctions described in this section are distinct from the sanctions, described earlier, for an institutional provider's failure to comply with quality standards.

1. CRIMINAL PENALTIES

The following Medicaid-related violations are crimes under Federal law:

- Making a false statement in an application for, or for use in determining the right to, a Medicaid payment or benefit.
- Failing to report a change affecting the right or continued right to a benefit.
- Applying for a benefit on behalf of another and then converting the benefit to one's own use.
- Claiming payment for a service by an unlicensed physician.
- Making a false statement to obtain certification as a hospital, nursing facility, or home health agency.
- Paying kickbacks (with exceptions for legitimate discounts or purchasing agent arrangements).
- Charging a beneficiary for a service reimbursed by Medicaid, except for any allowable cost-sharing amounts.
- "Supplementation," i.e., soliciting contributions from beneficiaries or their relatives as a condition for admission or continued in a nursing home or other facility.

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[10] U.S. Dept. of Health and Human Services. Office of the Inspector General. Semiannual report, April 1987–September 30, 1987. Washington. 1987

Some of these violations, such as a false application for benefits, may be committed by a beneficiary as well as by a provider; others are applicable to providers alone. A violation by a provider is a felony, punishable by imprisonment for up to 5 years and a fine of up to $25,000. Violations by beneficiaries or third parties are misdemeanors, punishable by imprisonment for up to 1 year and a fine of up to $10,000. When a beneficiary is convicted of a Medicaid-related offense, the State may exclude the beneficiary from Medicaid eligibility for up to 1 year. Other family members may not be excluded if otherwise eligible.

State laws may also provide for criminal penalties for fraudulent practices. States may have specific laws relating to Medicaid fraud or may rely on general statutes covering fraud or false pretenses. Some States have also adopted legislation providing criminal penalties for abuse of nursing home residents.

2. CIVIL MONETARY PENALTIES

The Secretary may, under procedures agreed to by the U.S. Attorney General and subject to judicial review, impose civil monetary penalties on Medicaid providers up to the following limits (the list excludes violations applicable only under Medicare):

- $2,000 for each item or service not provided as claimed or fraudulently claimed, provided by an unlicensed or otherwise unqualified physician, or furnished by a provider excluded from the program, plus an assessment of up to twice the amount claimed.
- $2,000 for each instance in which a provider charges a beneficiary an amount greater than permitted under the provider's agreement with the Medicaid agency or under any provision of Medicaid rules, plus an assessment of up to twice the amount claimed.
- $25,000 for each instance in which a health maintenance organization (HMO) or similar organization fails to provide medically necessary care to an enrollee, if the failure has adversely affected, or has a substantial likelihood of affecting, the enrollee.
- Up to $25,000 for each instance in which the Secretary determines that an HMO has imposed premiums on enrollees in excess of the premiums permitted under Medicaid law, plus double the amount of the overcharges. The overcharges must be deducted from any such penalties and refunded to the enrollees.
- Up to $100,000 for each instance in which the Secretary determines that an HMO has expelled or refused to reenroll beneficiaries on the basis of health status or need for health services, or has engaged in practices that could reasonably be expected to deny or discourage enrollment of beneficiaries likely to have a substantial need for services. The HMO may also be penalized an additional $15,000 for each individual not enrolled as a result of these practices.
- Up to $100,000 for each instance in which the Secretary determines that an HMO has misrepresented or falsified informa-

tion furnished to the Secretary, the State, or any other individual or entity.

- $2,000 for each beneficiary on whose behalf a hospital or HMO issues a payment to a physician as an incentive to reduce or limit services. The penalty may be imposed on both the provider issuing the payment and the physician accepting it. For HMOs, the requirement does not apply until April 1, 1990.
- Effective October 1, 1990, $2,000 for any case in which an individual notifies a nursing facility in advance of a standard scheduled survey. (As noted above, these surveys are supposed to be unannounced.)
- Effective October 1, 1990, $1,000 for certifying, or $5,000 for causing to be certified, a false statement in the assessment of a nursing home resident's functional capacity.

Again, individual States may have their own provisions for imposition of civil penalties. State law or regulations must provide for civil penalties for noncompliant nursing homes unless the State can demonstrate to the Secretary that it has equally effective alternative remedies.

3. EXCLUSION FROM PARTICIPATION

A State may exclude a provider from Medicaid participation on its own initiative or in response to action by the Secretary. If the Secretary excludes a provider from participation in Medicare, the State must exclude the provider from the Medicaid program. The Medicaid exclusion must last at least as long as the Medicare exclusion; the State may at its discretion provide for a longer exclusion period. The State may request a waiver of the requirement that it exclude from Medicaid a Medicare-excluded provider, if the State determines that the provider is an essential source of services for Medicaid beneficiaries. Exclusion is generally effective immediately upon notice to a provider, but may be delayed for patients receiving institutional, home health, or hospice services, if there is no immediate danger to their health and welfare.

The Secretary *must* exclude from Medicare (and hence the State must exclude from Medicaid) any provider who has been convicted of a crime involving the delivery of Medicare services or services under Medicaid or any other State health care program, or involving patient abuse or neglect.

The Secretary *may* exclude a provider, after notice and an opportunity for a hearing, for any of a long list of program violations. The major categories of bases for exclusion are as follows:

- Federal or State conviction of fraud, embezzlement, theft, other financial misconduct, obstruction of an investigation, or offenses related to controlled substances.
- Revocation or suspension of a provider's license for reasons of professional competence or performance or financial integrity, or voluntary surrender of that license while a formal disciplinary proceeding was pending.
- Exclusion or suspension from any Federal or State health program for reasons bearing on the provider's professional competence or performance or financial integrity. (The Secretary may thus exclude a provider from Medicare after one State ex-

cludes the provider from Medicaid; the exclusion then becomes binding on all other States' Medicaid programs.)

- Overcharging or providing excessive services or services that fail to meet professionally recognized standards under Medicare, Medicaid, or any other State health program.
- In the case of a health maintenance organization or a provider under a section 2175 case management program (see Chapter V) failure to provide necessary services, if the failure adversely affects or has a substantial likelihood of affecting the health of beneficiaries.
- Determination by the Secretary that a provider has committed any of the acts for which criminal or civil monetary penalties could be imposed, as described in sections 1 and 2, above.
- In the case of an institutional provider, being controlled or managed by an individual who has been excluded from program participation, subjected to civil monetary penalties, or convicted of certain crimes.
- Failure to make required disclosures relating to ownership, management or control of the provider by sanctioned individuals, or relationships between the provider and its subcontractors and suppliers.
- Failure to supply information needed to verify amounts payable by Medicare or a State health program, or to grant immediate access to Federal and State auditors, reviewers, or investigators.
- In the case of a hospital, failure to take corrective action after a finding that the hospital has provided inappropriate services under Medicare.
- Default on health education loan or scholarship obligations.

States are required to maintain their own administrative procedures for excluding providers from Medicaid. They must report any such action to the Inspector General, DHHS, and must also report any criminal convictions. In addition, the State must obtain information on ownership and management from all providers, and may act on its own to exclude a provider with an excludable owner or manager or which fails to make full disclosure. If the provider is a health maintenance organization (HMO) or similar organization, exclusion on this basis is mandatory.

4. LOCK-IN

A form of sanction known as "lock-in" is available for cases in which a beneficiary is determined to have made inappropriate or excessive use of services.[11] The State is permitted, after notice to the beneficiary and an opportunity for a hearing, to restrict the providers from whom the beneficiary may obtain care. Typically, the State will require the beneficiary to choose a single primary care physician. Except in emergencies, the beneficiary may obtain care from other providers only with the primary care physician's authorization.[12] In some States an effort is made to counsel beneficiaries and give them an opportunity to modify their own behavior before lock-in is imposed. A 1983 survey by the National Governors' Association found that 37 States had some form of beneficiary control system; those reporting on lock-in programs claimed average savings of $1,000 per beneficiary.

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[11] A parallel sanction for providers, known as "lock-out," was eliminated by the Medicare and Medicaid Patient and Program Protection Act of 1987 (Public Law 100-93). The lock-out provision gave the States the option of temporarily suspending a provider who furnished unnecessary services. It has been replaced by a provision authorizing the exclusion of such a provider from program participation; see above.

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[12] The arrangement may somewhat resemble the primary care case management programs described in Appendix F. Those programs, however, generally apply to entire populations rather than scattered individuals and are permitted only under a section 2175 waiver of Medicaid requirements approved by the Secretary.

CHAPTER VII. FINANCING [1]

SUMMARY

Medicaid services and associated administrative costs are financed jointly by the Federal government and the States. The Federal share of a State's payments for services is known as the Federal Medical Assistance Percentage (FMAP). FMAP's are recalculated annually. A State's FMAP can range from 50 percent to 83 percent, though currently the highest rate is 79.8 percent. The formula used to calculate the States' FMAPs is designed to provide a higher percentage of Federal matching payments to States with lower per capita incomes. The Federal share of administrative costs is 50 percent, though higher rates are applicable for specific items. In 1986, the Federal government's share of total payments was 55.6 percent for medical services and 59.1 percent of administrative costs.

The non-Federal portion of State Medicaid payments can be financed entirely through State funds. Alternatively, States may require local governments to share in financing a portion of program costs. However, the States themselves are required to provide financial participation equal to at least 40 percent of the non-Federal share of Medicaid expenditures.

Table VII–1 shows, by State, actual Federal and State expenditures for services and administrative costs for fiscal year 1986. Nationwide, administrative costs represented 4.8 percent of total expenditures. (See table VII–2).

Table VII–1.—TOTAL COMPUTABLE MEDICAID PAYMENTS AND FEDERAL AND STATE SHARE OF PAYMENTS, FISCAL YEAR 1986 [1]

State	Total	Federal share	State share	Medicaid vendor payments			Administrative costs		
				Total	Federal share	State share	Total	Federal share	State share
Alabama	$442,655	$319,991	$122,664	$427,319	$309,625	$117,694	$15,336	$10,366	$4,970
Alaska	87,018	45,551	41,467	82,487	43,056	39,431	4,531	2,495	2,036
American Samoa	3,193	1,150	2,043	3,193	1,150	2,043	0	0	0
Arizona	115,211	73,447	41,764	101,654	66,435	35,219	13,557	7,012	6,545
Arkansas	423,373	311,339	112,034	404,594	299,024	105,570	18,779	12,315	6,464
California	5,057,558	2,560,167	2,497,391	4,756,242	2,382,253	2,373,989	301,316	177,914	123,402
Colorado	331,316	167,207	164,109	314,119	157,159	156,960	17,197	10,048	7,149
Connecticut	703,741	354,432	349,309	672,678	336,891	335,787	31,063	17,541	13,522
Delaware	84,371	42,865	41,506	80,811	40,946	39,865	3,560	1,919	1,641
District of Columbia	329,772	166,717	163,055	311,842	156,279	155,563	17,930	10,438	7,492
Florida	1,066,797	600,117	466,680	1,022,953	574,780	448,173	43,844	25,337	18,507

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[1] This chapter was written by Jennifer O'Sullivan. Tables VII–1 and VII–2 were prepared by Keith Hurt.

Table VII-1.—TOTAL COMPUTABLE MEDICAID PAYMENTS AND FEDERAL AND STATE SHARE OF PAYMENTS, FISCAL YEAR 1986 [1]—Continued

State	Total	Federal share	State share	Medicaid vendor payments			Administrative costs		
				Total	Federal share	State share	Total	Federal share	State share
Georgia	859,071	564,589	294,482	820,638	542,180	278,458	38,433	22,409	16,024
Guam	3,534	1,782	1,752	3,096	1,548	1,548	438	234	204
Hawaii	149,216	77,483	71,733	140,149	71,879	68,270	9,067	5,604	3,463
Idaho	86,749	60,047	26,702	81,987	56,963	25,024	4,762	3,084	1,678
Illinois	1,813,013	916,934	896,079	1,736,538	873,721	862,817	76,475	43,213	33,262
Indiana	890,479	558,323	332,156	861,763	542,692	319,071	28,716	15,631	13,085
Iowa	393,017	232,754	160,263	377,670	223,284	154,386	15,347	9,470	5,877
Kansas	286,694	145,450	141,244	273,980	137,595	136,385	12,714	7,855	4,859
Kentucky	585,434	409,607	175,827	557,073	392,069	165,004	28,361	17,538	10,823
Louisiana	836,647	533,603	303,044	805,478	515,282	290,196	31,169	18,321	12,848
Maine	271,044	185,852	85,192	257,999	177,941	80,058	13,045	7,911	5,134
Maryland	743,977	377,743	366,234	709,052	356,851	352,201	34,925	20,892	14,033
Massachusetts	1,749,948	881,924	868,024	1,682,246	842,490	839,756	67,702	39,434	28,268
Michigan	1,869,733	1,070,956	798,777	1,774,473	1,015,047	759,426	95,260	55,909	39,351
Minnesota	1,082,466	580,305	502,161	1,029,665	551,360	478,305	52,801	28,945	23,856
Mississippi	348,593	271,193	77,400	337,440	264,176	73,264	11,153	7,017	4,136
Missouri	596,639	361,892	234,747	572,765	348,158	224,607	23,874	13,734	10,140
Montana	123,586	82,775	40,811	116,309	77,856	38,453	7,277	4,919	2,358
Nebraska	201,062	115,371	85,691	188,899	108,223	80,676	12,163	7,148	5,015
Nevada	85,387	43,283	42,104	79,394	40,032	39,362	5,993	3,251	2,742
New Hampshire	152,647	85,377	67,270	142,694	78,770	63,924	9,953	6,607	3,346
New Jersey	1,356,625	691,993	664,632	1,285,345	646,139	639,206	71,280	45,854	25,426
New Mexico	180,640	125,497	55,143	171,540	119,588	51,952	9,100	5,909	3,191
New York	8,667,152	4,381,922	4,285,230	8,292,137	4,157,284	4,134,853	375,015	224,638	150,377
North Carolina	792,781	544,546	248,235	756,405	524,551	231,854	36,376	19,995	16,381
North Dakota	126,314	69,770	56,544	118,369	65,160	53,209	7,945	4,610	3,335
Northern Mariana Islands	1,083	544	539	989	495	494	94	49	45
Ohio	2,088,791	1,227,426	861,365	2,021,167	1,187,934	833,233	67,624	39,492	28,132
Oklahoma	519,401	298,608	220,793	479,605	277,078	202,527	39,796	21,530	18,266
Oregon	308,332	190,862	117,470	272,069	168,867	103,202	36,263	21,995	14,268
Pennsylvania	2,262,146	1,289,993	972,153	2,158,311	1,228,797	929,514	103,835	61,196	42,639
Puerto Rico	146,595	63,400	83,195	132,900	57,846	75,054	13,695	5,554	8,141
Rhode Island	279,417	157,334	122,083	271,486	153,127	118,359	7,931	4,207	3,724
South Carolina	423,264	304,653	118,611	400,590	291,344	109,246	22,674	13,309	9,365
South Dakota	105,917	72,891	33,026	103,386	71,301	32,085	2,531	1,590	941
Tennessee	763,717	534,444	29,273	730,439	513,394	217,045	33,278	21,050	12,228
Texas	1,667,489	905,239	762,250	1,551,578	833,475	718,103	115,911	71,764	44,147
Utah	199,859	143,684	56,175	184,709	134,273	50,436	15,150	9,411	5,739
Vermont	102,327	68,522	33,805	94,049	63,306	30,743	8,278	5,216	3,062
Virginia	647,124	345,784	301,340	612,261	326,237	286,024	34,863	19,547	15,316
Virgin Islands	4,688	2,100	2,588	4,150	1,806	2,344	538	294	244
Washington	697,990	354,349	343,641	653,774	329,407	324,367	44,216	24,942	19,274
West Virginia	222,497	158,458	64,039	211,843	151,642	60,201	10,654	6,816	3,838
Wisconsin	1069,536	617,896	451,640	1,030,708	594,865	435,843	38,828	23,031	15,797
Wyoming	34,280	17,251	17,029	32,859	16,517	16,342	1,421	734	687
Total	44,441,906	24,767,392	19,674,514	42,297,869	23,500,148	18,797,721	2,144,037	1,267,244	876,793

[1] Includes adjustments; data subject to revision.

Source: Form HCFA-64, Quarterly Statement of Medicaid Expenditures for the Medical Assistance Program.

Table VII–2.—ADMINISTRATIVE COSTS AS A PERCENT OF TOTAL MEDICAID PAYMENTS, FISCAL YEAR 1986

State	Administrative costs as a percent of Medicaid payments
Alabama	3.46
Alaska	5.21
Arizona	11.77
Arkansas	4.44
California	5.96
Colorado	5.19
Connecticut	4.41
Delaware	4.22
District of Columbia	5.44
Florida	4.11
Georgia	4.47
Hawaii	6.08
Idaho	5.49
Illinois	4.22
Indiana	3.22
Iowa	3.90
Kansas	4.43
Kentucky	4.84
Louisiana	3.73
Maine	4.81
Maryland	4.69
Massachusetts	3.87
Michigan	5.09
Minnesota	4.88
Mississippi	3.20
Missouri	4.00
Montana	5.89
Nebraska	6.05
Nevada	7.02
New Hampshire	6.52
New Jersey	5.25
New Mexico	5.04
New York	4.33
North Carolina	4.59
North Dakota	6.29
Ohio	3.24
Oklahoma	7.66
Oregon	11.76
Pennsylvania	4.59
Rhode Island	2.84
South Carolina	5.36
South Dakota	2.39
Tennessee	4.36
Texas	6.95
Utah	7.58
Vermont	8.09
Virginia	5.39
Washington	6.33
West Virginia	4.79
Wisconsin	3.63
Wyoming	4.15
American Samoa	[1] N/A
Guam	12.39

Table VII-2.—ADMINISTRATIVE COSTS AS A PERCENT OF TOTAL MEDICAID PAYMENTS, FISCAL YEAR 1986—Continued

State	Administrative costs as a percent of Medicaid payments
Northern Mariana Islands	8.68
Puerto Rico	9.34
Virgin Islands	6.33
Total	4.82

[1] Entries with N/A indicate not available.

Source: Congressional Research Service (CRS) analysis of data from Form HCFA-64, Quarterly Statement of Medicaid Expenditures for the Medical Assistance Program.

I. AUTHORIZATIONS/APPROPRIATIONS

Medicaid is an entitlement program; the Federal government matches State expenditures, provided Federal requirements are met. The program's substantive rules are established by the Congressional authorizing committees.

Federal Medicaid funding is provided from general revenues. The funds are appropriated each year to meet claims submitted by the States for covered services and administrative costs. The funding levels are contained in the appropriations bill developed by the Congressional appropriations committees. The appropriations bills specify a fixed amount of "grants to the States" for the fiscal year, with such amounts to remain available until expended. In general, they also authorize, beginning with the last quarter of the prior year "such sums as may be necessary" for unanticipated costs incurred in that year and a specified amount for the first quarter of the following fiscal year.

The Balanced Budget and Emergency Deficit Control Act of 1985 (commonly referred to as Gramm-Rudman-Hollings), as amended by the Balanced Budget and Emergency Deficit Control Reaffirmation Act (referred to as the 1987 Reaffirmation Act) provides for an automatic trigger for sequestration procedures for government programs if the estimated deficit exceeds the deficit target. Expenditures under Medicaid are exempt from these sequestration procedures. However, HCFA program management activities are not exempt from the sequestration process.

II. FEDERAL PARTICIPATION IN THE COST OF SERVICES

A. General Requirements

The Federal Government shares in the cost of Medicaid services with the States by means of a variable matching formula that is adjusted annually. The Federal share of a State's medical vendor payments is called the Federal Medical Assistance percentage (FMAP). The statutory formula for determining the FMAP follows:

FMAP = 100 PERCENT—State share

$$\text{State share} = \frac{(\text{State per capita income})^2}{(\text{National per capita income})^2} \text{ X 45 percent}$$

This formula is designed to provide a higher percentage of Federal matching to States with lower per capita incomes and a lower percentage of matching for States with higher per capita incomes. Under the formula, if a State's per capita income is equal to the national average, the Federal share would be 55 percent. The law establishes a minimum FMAP of 50 percent and a maximum of 83 percent (though the highest rate currently in effect is 79.80 percent.)[2]

By law, the Secretary of HHS promulgates the FMAP between October 1 and November 1 of each year. This FMAP is in effect for the 1-year period beginning the following October. The percentages are based on the average per capita income of each State and the United States for the three most recent calendar years for which satisfactory data are available from the Department of Commerce. Prior to 1987, the FMAP was calculated and applied on a biennial basis. Beginning in fiscal year 1987, the FMAP was recalculated annually. However, the change to the annual calculation did not apply, for fiscal year 1987 only, to those States which would be adversely affected by the change. Table VII-3 shows the FMAP by State for fiscal year 1986— fiscal year 1989. For fiscal year 1989, 12 States (including the District of Columbia) have FMAPs of 50 percent. Fourteen States have FMAPs between 50 percent and 60 percent. Twelve States have FMAPs between 60 percent and 70 percent; and 13 States have FMAPs over 70 percent.

By law, the Federal matching rate for the territories is set at 50 percent and a maximum annual dollar limit is placed on the amount each territory can receive. The dollar limits in effect for fiscal year 1988, fiscal year 1989, and for fiscal year 1990 and subsequent years are shown in Table VII-4.

Table VII-3.—FEDERAL MEDICAL ASSISTANCE PERCENTAGES, FISCAL YEARS 1986-89

State	Fiscal Year 1986	Fiscal Year 1987	Fiscal Year 1988	Fiscal Year 1989
Alabama	72.30	72.41	73.29	73.10
Alaska	50.00	50.00	50.00	50.00
Arizona	62.28	[1] 62.28	62.12	62.04
Arkansas	73.83	74.02	74.21	74.14
California	50.00	50.00	50.00	50.00
Colorado	50.00	50.00	50.00	50.00

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[2] The General Accounting Office, pursuant to a requirement contained in the Omnibus Budget Reconciliation Act of 1981, examined the Medicaid matching formula relative to certain policy objectives. The report, Changing Medicaid Formula Can Improve Distribution of Funds to States (GAO/GGD-83-27, March 9, 1983), concluded that: "the formula is not as equitable to States as it could be. This is because per capita income—a key formula factor—does not adequately reflect the greater tax burden of States with a high proportion of the needy and because it is not the best available measure of States' ability to finance Medicaid from State revenue sources. The formula also contributes to the wide disparity in benefits provided under State Medicaid programs."

Table VII-3.—FEDERAL MEDICAL ASSISTANCE PERCENTAGES, FISCAL YEARS 1986-89—Continued

State	Fiscal Year 1986	Fiscal Year 1987	Fiscal Year 1988	Fiscal Year 1989
Connecticut	50.00	50.00	50.00	50.00
Delaware	50.00	50.00	51.90	52.60
District of Columbia	50.00	50.00	50.00	50.00
Florida	56.16	[1] 56.16	55.39	55.18
Georgia	66.05	[1] 66.05	63.84	62.78
Hawaii	51.00	51.29	53.71	53.99
Idaho	69.36	71.08	70.47	72.71
Illinois	50.00	50.00	50.00	50.00
Indiana	62.82	62.92	63.71	63.71
Iowa	58.90	60.39	62.75	62.95
Kansas	50.00	51.39	55.20	54.93
Kentucky	70.23	70.75	72.27	72.89
Louisiana	63.81	65.77	68.26	71.07
Maine	68.86	[1] 68.86	67.08	66.68
Maryland	50.00	50.00	50.00	50.00
Massachusetts	50.00	50.00	50.00	50.00
Michigan	56.79	56.88	56.48	54.75
Minnesota	53.41	[1] 53.41	53.98	53.07
Mississippi	78.42	78.50	79.65	79.80
Missouri	60.62	[1] 60.62	59.27	59.96
Montana	66.38	67.44	69.40	70.62
Nebraska	57.11	58.06	59.73	60.37
Nevada	50.00	50.00	50.25	50.00
New Hampshire	54.92	[1] 54.92	50.00	50.00
New Jersey	50.00	50.00	50.00	50.00
New Mexico	68.94	69.68	71.52	71.54
New York	50.00	50.00	50.00	50.00
North Carolina	69.18	[1] 69.18	68.68	68.01
North Dakota	55.12	56.41	64.87	66.53
Ohio	58.30	[1] 58.30	59.10	58.98
Oklahoma	57.60	59.86	63.33	66.06
Oregon	61.54	62.47	62.11	62.44
Pennsylvania	56.72	57.28	57.35	57.42
Rhode Island	56.33	[1] 56.33	54.85	55.88
South Carolina	72.70	[1] 72.70	73.49	73.08
South Dakota	67.82	[1] 67.82	70.43	71.02
Tennessee	70.20	70.26	70.64	70.17
Texas	53.56	55.16	56.91	59.04
Utah	72.62	73.21	73.73	73.86
Vermont	67.06	67.37	66.23	63.92
Virginia	53.14	[1] 53.14	51.34	51.20
Washington	50.06	52.52	53.21	53.06
West Virginia	71.53	72.59	74.84	76.14
Wisconsin	57.54	57.58	58.98	59.31
Wyoming	50.00	54.20	57.96	62.61
American Samoa	50.00	50.00	50.00	50.00
Guam	50.00	50.00	50.00	50.00
N. Mariana Islands	50.00	50.00	50.00	50.00
Puerto Rico	50.00	50.00	50.00	50.00
Virgin Islands	50.00	50.00	50.00	50.00

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[1] The hold harmless provision enacted as part of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509), gave these 13 States the right to use their 1986 FMAP rates for fiscal year 1987.

Source: Commerce Clearing House. Medicare and Medicare Guide.

Table VII-4.—MAXIMUM ANNUAL PAYMENTS TO THE TERRITORIES

Territory	Fiscal Years 1985-87	Fiscal Year 1988	Fiscal Year 1989	Fiscal Year 1990 and After
American Samoa	$1,150,000	$1,330,000	$1,390,000	$1,450,000
Guam	2,000,000	2,320,000	2,410,000	2,500,000
Northern Mariana Islands	550,000	636,700	693,350	750,000
Puerto Rico	63,400,000	73,400,000	76,200,000	79,000,000
Virgin Islands	2,100,000	2,430,000	2,515,000	2,600,000

Source: Table prepared by Congressional Research Service based on Social Security Act, Section 1108 (42 U.S.C. 1308).

B. Special Matching Rates

The law specifies that the FMAP for services received through an Indian Health Service facility (whether operated by the Indian Health Service or by an Indian tribe or tribal organization) is 100 percent.[3] Further, family planning services are matched at a 90 percent rate.

III. ADMINISTRATIVE MATCHING RATES

A. General Provisions

The law specifies a Federal matching rate of 50 percent for administrative costs with the following exceptions:

—75 percent for compensation and training of professional medical personnel, and staff directly supporting such personnel, used in program administration;

—90 percent for development and 75 percent for operation of automated claims processing systems;[4]

—75 percent for medical and utilization review or for quality review by a utilization and quality control peer review organization (PRO);

—100 percent for implementing and operating an immigration status verification system; and

—90 percent for the first 3 years and 75 percent thereafter for establishing and operating a state Medicaid fraud control unit, subject to a limit of the higher of $125,000 or .025 percent of total Federal and State expenditures in the State.

B. Nursing Facility Provisions

Public Law 100-203, Omnibus Budget Reconciliation Act of 1987 (OBRA87) eliminates, effective October 1, 1990, the current law distinction between Skilled Nursing Facilities (SNFs) and Intermediate Care Facilitites (ICFs) participating in Medicaid. These facilities will all be referred to as nursing facilities and the services provided in them referred to as nursing services. On and after October 1, 1990, all nursing facilities participating in Medicaid will have to meet a single set of requirements relating to the provision of services, resident's rights, administration, and other matters. OBRA87, and technical amendments contained in Public Law 100–360, Medicare Catastrophic Coverage Act of 1988 provide increased Federal matching funds for the following activities related to implementation of the new requirements:

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[3] For a discussion of reimbursement for services provided by or through the Indian Health Service; see Chapter IV. See Appendix F for a discussion of the dispute (and related litigation) between Arizona and the Department concerning the responsibility of the Arizona Health Care Cost Containment System (AHCCCS) for services to Indians.

[4] States which do not have such systems are subject to reductions in Federal funding; see Chapter VI.

—By January 1, 1989, States are required to specify nurse aide training and competency evaluation programs meeting specified requirements; by January 1, 1990, States are required to provide for review and reapproval of such programs. The matching rate for any additional amounts expended for such activities during the eight calendar quarters beginning July 1988, is the FMAP plus 25 percentage points not to exceed 90 percent. The rate is 50 percent in subsequent years.

—Effective January 1, 1989, each State must have in effect a preadmission screening program for all mentally ill or mentally retarded individuals to determine whether placement in a SNF or ICF is appropriate. As of April 1, 1990, a State must have reviewed all mentally ill or mentally retarded individuals in nursing facilities to determine whether continued placement is appropriate, and must arrange for the safe and orderly discharge and active treatment of residents for whom continued placement is inappropriate. The matching rate for these activities is 75 percent.

—Effective October 1, 1990, a new survey and certification process is established. Federal matching payments for these activities will be 90 percent in fiscal year 1991, 85 percent in 1992, 80 percent in fiscal year 1993, and 75 percent thereafter.

IV. STATE AND LOCAL FUNDING

The non-Federal portion of State Medicaid payments can be financed entirely through State funds. Alternatively States may require local governments to share in financing a portion of program costs. However, the States themselves are required to provide financial participation equal to at least 40 percent of the non-Federal share of Medicaid expenditures. As of March 31, 1986, fourteen States required local funding of at least some portion of medical vendor payments. (See table VII–5.)

Table. VII–5.—LOCAL FUNDING FORMULAS FOR MEDICAID VENDOR PAYMENTS AS OF MARCH 31, 1986

Colorado	Twenty largest counties pay 2 percent of State's share for all new ICF nursing home admissions.
Florida	Counties pay 35 percent of cost or $55.00 per month, whichever is less, for each nursing home resident; 35 percent of cost for inpatient hospital days over 12 and less than 46;
Iowa	Counties match Federal funds for ICFs/MR.
Minnesota	Counties pay 10 percent of State's share.
Montana	Counties pay 18 percent of eligibility personnel costs.
Nebraska	Counties pay 4.67 percent of total expenditures.
New Hampshire	Local contribution of approximately 25 percent of nursing home costs, excluding residents in State institutions.
New York	Counties pay 50 percent of non-Federal share, except for long term care for which they pay 28 percent of non-Federal, 20 percent in 1986.
North Carolina	Counties pay 15 percent of non-Federal share for all services.
North Dakota	Counties pay 15 percent of State share except for ICFs/MR, clinic services, and waivered home and community based services for mentally retarded, aged and disabled recipients.

Table. VII–5.—LOCAL FUNDING FORMULAS FOR MEDICAID VENDOR PAYMENTS AS OF MARCH 31, 1986—Continued

Pennsylvania	Counties pay 10 percent of State's share for county nursing homes plus $3 per invoice administration fee.
South Dakota	Sixty dollars per month for each ICF/MR resident and local school district for crippled childrens' hospital.
Utah	Local contribution of less than 1 percent for specific services (e.g., mental health).
Wisconsin	Local contribution of 10–20 percent for mental health services.

Source: U.S. Department of Health and Human Services, Health Care Financing Administration. Analysis of State Medicaid Program Characteristics. 1986. p. 120.

Under current Medicaid regulations, private funds donated to the Medicaid agency and used by the agency to furnish medical assistance may be counted as State expenditures for the purpose of computing Federal financial participation. The funds must actually be transferred to the Medicaid agency and be under the agency's administrative control. They must not revert to the donor's facility or use unless the facility is a non-profit organization and the Medicaid agency, of its own volition, decides to use the donor's facility.[5]

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[5] 42 C.F.R. 433.45.

CHAPTER VIII. RECENT LEGISLATIVE HISTORY [1]

SUMMARY

Beginning in 1980, budget reconciliation bills have been the major legislative vehicle for changes in the Medicaid program. The intent of these reconciliation bills has been to provide for reductions in Federal spending across government programs. However, the bills enacted between 1984 and 1987 provided for slight increases in Medicaid outlays. In addition to reconciliation bills, two other laws also included significant legislative changes.

Taken together, these measures have resulted in several significant changes in the nature of the Medicaid program—the most significant of which are the increased flexibilities given States in the design and administration of their programs and in the expansion in the eligible population.

In 1981, both in response to rapidly escalating program costs and to an Administration proposal to cap Federal Medicaid expenditures, the Congress approved temporary reductions in Federal Medicaid payments. However, of greater long-term significance for the program were the increased flexibilities authorized under the freedom-of-choice and home and community based services waiver authorities. (See discussion below). This flexibility has been cited as a factor in encouraging States to explore alternative health services delivery approaches. The legislation also continued the process begun in 1980 of allowing States increased flexibility in determining reimbursement rates for institutional services. Subsequent legislation further modified and clarified these authorities.

In 1984, Congress began a gradual expansion in the population groups State Medicaid programs are both required and permitted to cover. This expansion continued through the recently enacted Medicare catastrophic legislation. A connection to cash assistance is still the primary, but no longer the only way to establish Medicaid eligibility. When the current statutory requirements are fully implemented, States will be required to cover all pregnant women and infants below the Federal poverty line and all children under 7 meeting State eligibility standards. Further, States will be required to pay Medicare cost-sharing charges for elderly and disabled Medicare beneficiaries with incomes below the poverty line.

This chapter reviews the major legislative changes which have been enacted over the 1980–88 period. These changes were incorporated in seven reconciliation bills, one antifraud measure, and the Medicare catastrophic legislation as follows:

—Public Law 96–499, Omnibus Reconciliation Act of 1980 (ORA80),

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[1] This chapter was written by Jennifer O'Sullivan.

- —Public Law 97–35, Omnibus Budget Reconciliation Act of 1981 (OBRA81),
- —Public Law 97–248, Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA),
- —Public Law 98–369, Deficit Reduction Act of 1984 (DEFRA),
- —Public Law 99–272, Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA),
- —Public Law 99–509, Omnibus Budget Reconciliation Act of 1986 (OBRA 86),
- —Public Law 100–93, Medicare and Medicaid Patient and Program Protection Act of 1987,
- —Public Law 100–203, Omnibus Budget Reconciliation Act of 1987 (OBRA 87), and
- —Public Law 100–360, Medicare Catastrophic Coverage Act of 1988.

The following highlights the major changes incorporated in these laws. More details are contained in the following sections of these chapters.

—*Eligibility Expansions*

—*Coverage of pregnant women, infants and young children.* Beginning with DEFRA, legislation expanded requirements with respect to coverage of pregnant women and children. States are now required to cover all pregnant women meeting the States' income and resources requirements, whether or not they are receiving cash assistance. They are also required to phase-in coverage of all children under age 7, born after September 30, 1983, who meet such income and resources requirements.

Beginning in 1987, States could expand their programs to provide coverage for pregnant women and young children with incomes above the cash assistance standard but below the Federal poverty line. States may now cover pregnant women and children under age 5 born after September 30, 1983; beginning October 1, 1988 they may phase-in coverage of such children under age 8. Beginning in July 1988, States have the option of covering pregnant women and infants below 185 percent of the poverty line.

Public Law 100–360 requires States to cover pregnant women and infants below 75 percent of poverty, effective July 1, 1989 and below 100 percent of poverty, effective July 1, 1990.

—*Coverage of elderly and disabled poor.* Beginning in 1987, States were permitted to provide Medicaid coverage to elderly and disabled persons with incomes above the cash assistance standard but below the Federal poverty line. Alternatively they could cover just the Medicare cost-sharing charges for this population group.

Public Law 100–360 requires States to phase-in, generally over 4 years, coverage of Medicare cost-sharing charges for all elderly and disabled persons below the Federal poverty line.

—*Coverage of Working Disabled Persons.* OBRA86 required States to continue Medicaid coverage for disabled persons with severe impairments who lose their eligibility for cash assistance because of their earnings from work.

—*Increased Flexibility for States in Establishing Payment Rates.*

—*Payments to Skilled Nursing and Intermediate Care Facilities.* Prior to enactment of ORA80, States were required to pay for SNF and ICF services on a "reasonable cost" basis. ORA80 repealed this requirement. It permitted States to reimburse such facilities at rates that are reasonable and adequate to meet the cost which must be incurred by efficiently and economically operated facilities in order to provide care in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

OBRA87 eliminates, effective October 1, 1990, the distinction between SNFs and ICFs and at the same time eliminates the requirement that States pay less for ICF than for SNF services. States are also required to adjust their payment rates to reflect the costs facilities incur in implementing the 1987 reforms.

—*Payments to Hospitals.* OBRA81 eliminated the requirement that States pay for hospital services on a reasonable cost basis; it gave States increased flexibility to develop their payment rates, comparable to that authorized for SNFs and ICFs under ORA80. At the same time States were required to take into account the situation of hospitals serving a disproportionate number of low-income patients. This "disproportionate share" provision was strengthened several times in subsequent legislation.

—*Increased Flexibility in Delivery of Services.*

—*"Freedom of Choice Waiver".* OBRA81 authorized the Secretary to waive certain State plan requirements to enable a State to restrict the provider from or through whom the individual could obtain nonemergency services.

—*Home and Community-Based Services Waivers.* OBRA81 authorized the Secretary to waive Federal requirements to enable a State to provide home and community-based services (other than room and board) to individuals who would otherwise require SNF or ICF services which would be paid by Medicaid. Services which could be provided under these waivers included certain supportive services not normally covered by Medicaid. Subsequent amendments to the original waiver authority generally addressed issues raised by implementing regulations and/or administration of the program by HCFA.

—*Nursing Home Reform.* OBRA87 contained major nursing home revisions for both Medicaid and Medicare. Beginning October 1, 1990, all nursing facilities participating in Medicaid will have to meet a single set of quality standards pertaining to the provision of services, resident's rights, and administration. The law also established a new process for State and Federal monitoring of nursing facility compliance with the new Medicaid requirements.

—*Expansion in the Types of Services Offered under State Medicaid Programs.* ORA80 required States to cover nurse midwife services. Subsequent legislation expanded the list of services

States may offer to include hospice care, targeted case management and home respiratory care for ventilator dependent persons.

—*Expansion of Penalty and Enforcement Remedies.* OBRA81 authorized the Secretary to impose civil monetary penalties for fraudulent Medicaid and Medicare claims; these were in addition to the criminal penalties already included in the law. OBRA86 expanded the actions for which such penalties could be imposed. Public Law 100–93 expanded the antifraud provisions in the law and clarified the criminal and civil penalty provisions.

Recent laws have also expanded intermediate sanction provisions relating to compliance violations by institutional long-term facilities.

—*Deterring Financial Gaming In Order to Qualify for Nursing Home Benefits.* Beginning in 1982, legislation was enacted to prevent persons with substantial assets from gaining eligibility for Medicaid prior to spending excess assets on medical care. TEFRA strengthened existing provisions relating to liens and to treatment of resources transferred for less than fair market value. COBRA added potential payments from Medicaid qualifying trusts to the list of income and resources available to an individual and therefore considered in determining eligibility. Public Law 100–360 established a national transfer of assets policy. In addition, it protects resources, but only up to a specified maximum, for the needs of the spouse of an institutionalized individual.

This chapter provides a further background on the legislative history of Medicaid since 1980. The discussion is divided into eight parts: eligibility, services, reimbursement, alternative delivery systems, administration, financing, long-term care, and antifraud measures. The final section of this chapter outlines the estimates, made at the time of enactment of the 1981–87 reconciliation bills and the catastrophic bill, of additional costs or savings.

I. ELIGIBILITY

The two major eligibility changes incorporated in recent legislation have been first, the expansions in required and optional coverage of low income pregnant women and children, and second, the expansions in coverage for the low-income elderly and disabled. Recent legislation also included several other modifications to Medicaid eligibility requirements including giving States more flexibility in designing their medically needy programs, requiring them to cover the working disabled who lose cash assistance, and strengthening requirements in order to deter financial gaming on the part of those seeking to qualify for nursing home benefits.

A. Required Coverage for Pregnant Women and Children Meeting AFDC Income and Resources Requirements but Not Otherwise Receiving AFDC or Medicaid

OBRA81 included certain limitations on AFDC coverage which had the effect of limiting required Medicaid coverage. It limited AFDC eligibility to children under age 18, or at State option under

19, but only if the child was a full-time student in a secondary or technical school and could reasonably be expected to complete the program before reaching age 19. The law further provided that States could limit Medicaid coverage to any person under age 19 who met the definition of dependent child under AFDC. At State option, States could extend Medicaid to all persons between the ages of 18 and 20 or any reasonable classification of such persons. OBRA81 also prohibited States from making AFDC cash payments to a pregnant woman on the basis of her unborn child until the sixth month of pregnancy. However, States were permitted to extend Medicaid eligibility to these women from the time pregnancy had been medically verified.

Beginning with DEFRA, major changes occurred in Federal policies relating to the coverage of pregnant women and children. These changes can be divided into two groups—first, those relating to coverage of persons meeting AFDC income and resources requirements but not otherwise eligible for Medicaid, and second, those relating to coverage of persons with incomes above the State AFDC standard but below the Federal poverty line. (See item B below for discussion of this second group).

DEFRA required States to cover certain pregnant women and children even though they were not actually receiving cash assistance. DEFRA required States to provide coverage to the following groups of persons meeting State AFDC income and resources requirements:

—First time pregnant women from medical verification of pregnancy;

—Pregnant women in two-parent families where the principal breadwinner was unemployed, from the medical verification of pregnancy; and

—Children born after September 30, 1983, up to age 5.

DEFRA also provided that a child born to a woman eligible for and receiving Medicaid at the time of birth was deemed eligible for 1 year as long as the woman remained eligible.

COBRA expanded these provisions by requiring States to provide Medicaid coverage to pregnant women in two-parent families that meet AFDC income and resources standards even where the principal breadwinner was not unemployed. COBRA also specified that States were not required to extend comparable benefits to other beneficiaries when they provide additional services related to pregnancy to all pregnant women. States were required to provide postpartum coverage to eligible pregnant women until the end of the 60 day period beginning on the last day of their pregnancy.

OBRA87 further expanded the required coverage of children meeting the income and resources requirements of the State's Medicaid plan. A State was required to extend Medicaid coverage to all such children under age 7 (or at State option under age 8) born after September 30, 1983.

B. Target Eligibility Groups

1. COVERAGE OF PREGNANT WOMEN AND INFANTS

OBRA86 created a new optional categorically needy group composed of pregnant women, infants up to age one, and on an incremental basis, children up to age 5 with family incomes below a State established level. States could choose an income level between the AFDC level and 100 percent of the Federal poverty line. Imposition of resource standards was optional with the States. The provision was effective April 1, 1987 for pregnant women and infants. Beginning in fiscal year 1988, States could increase the age level by one in each fiscal year until all children under age 5 were included. States could not elect to cover one age group unless all younger age groups were covered.

OBRA87 included provisions which allowed States to expand the scope of coverage under this provision. It permitted States to accelerate coverage of children under age 5 whose income was below the poverty line. Effective July 1, 1988, States could cover children under age 2, 3, 4, or 5 (as selected by the State) who were born after September 30, 1983. Effective October 1, 1988, States could expand coverage to children under age 8 born after September 30, 1983. States would thus be able to cover all such children by fiscal year 1991.

OBRA87 also permitted States, effective July 1, 1988 to increase the State-established income level for pregnant women and infants (up to age 1) with incomes up to 185 percent of the Federal poverty level. States could impose a premium for such coverage. The amount of the premium could not exceed 10 percent of the amount by which the family's income (less child care expenses) exceeded 150 percent of the poverty line for a comparable sized family.

Public Law 100–360 mandated coverage for certain pregnant women and infants whose coverage was previously optional with the States. It required States to phase-in coverage of pregnant women and infants with incomes below 100 percent of the poverty line. Effective July 1, 1989, States are required to cover such persons with incomes at or below 75 percent of poverty and effective July 1, 1990, States are required to cover those with incomes below 100 percent of poverty.

2. COVERAGE OF ELDERLY AND DISABLED POOR

OBRA86 created a second new optional categorically needy coverage group composed of the aged and disabled with family incomes up to a State-established level that did not exceed 100 percent of the Federal poverty line. A State choosing this option would have to offer the benefit package available to other categorically needy recipients. As an alternative, States could cover just the Medicare cost-sharing charges for this population group. (This is sometimes referred to as buy-in coverage). In either case, States would be required to use the SSI resource standards, except that if it had a medically needy program with higher standards it could use the higher standards for the new group. A State electing expanded coverage of the aged and disabled would be required to cover some newly eligible pregnant women and infants as described in Item (a). States could begin offering expanded coverage under this provision effective July 1, 1987.

Public Law 100–360 required States to phase-in buy-in coverage for poor Medicare beneficiaries with incomes below the poverty line. Specifically, the law required States to pay Medicare premiums, deductibles and coinsurance for elderly and disabled individuals whose incomes are at or below the poverty line and whose nonexempt resources are at or below twice the resource standard used under the SSI program. In all but five States the standard would be phased in over 4 years with coverage extended as follows: January 1989— persons with incomes at or below 85 percent of poverty, January 1, 1990— persons with incomes at or below 90 percent of poverty, January 1, 1991—persons with incomes at or below 95 percent of poverty, and January 1, 1992-all persons with incomes below 100 percent of poverty. In the five States using Medicaid income criteria more restrictive than SSI, the threshold would be set at 80 percent of poverty on January 1, 1989, increasing five percentage points each year.

Public Law 100–360 provided, beginning January 1, 1991, Medicare coverage for prescription drugs, subject to a $600 deductible and 50 percent coinsurance charges. The deductible is slated to go to $652 in 1992. In subsequent years, the deductible is to be set so that 16.8 percent of beneficiaries have drug expenditures exceeding the deductible in each year. Once the beneficiary has expenses exceeding the deductible, the program will make payments for the remainder of the calendar year, subject to the required coinsurance. The coinsurance is slated to be lowered to 20 percent by 1993. The law requires State Medicaid programs, on a phased-in basis to pay the additional premiums, deductibles, and coinsurance amounts for Medicare beneficiaries. The law gave States the option of meeting the deductible requirement by either covering incurred drug charges below the Medicare deductible or providing the same drug coverage as the State offers to its Medicaid beneficiaries.

C. Coverage of and Services for the Medically Needy

1. EXPANDED FLEXIBILITY FOR STATES

OBRA81 modified existing law pertaining to conditions a State had to meet if it chose to offer coverage to its medically needy population. It repealed the requirements that: (1) coverage had to be provided to all medically needy groups (i.e. aged, blind, disabled, and members of families with dependent children); (2) services for all medically needy groups had to be comparable in amount, duration, and scope; (3) States had to offer a minimum set of services to this population group; and (4) States had to offer a mix of institutional and noninstitutional care and services. OBRA81 placed the following requirements on State medically needy programs. If a State provided medically needy coverage for any population group, it had to provide ambulatory services for children and prenatal and delivery services for pregnant women. If a State provided institutional services for any medically needy group, it was also required to provide ambulatory services for this population. Further, if a State provided medically needy coverage for persons in intermediate care facilities for the mentally retarded (ICFs/MR), it had to offer to all covered medically needy groups a minimum set of services, as required under prior law.

2. MEDICAID MORATORIUM

TEFRA amended the Medicaid statute to clarify that Congress did not intend to change the policies governing income and resources standards and methodologies for determining eligibility of the medically needy from those in effect prior to OBRA. The TEFRA provision specified that the methodology to be used in determining income and resource eligibility for the medically needy must be the same methodology used under the relevant cash assistance program. The DEFRA conference report stated that a strict interpretation of this provision led to unintended consequences. DEFRA therefore established a moratorium period during which the Secretary was directed not to take any compliance, disallowance penalty or other regulatory action against a State because a State in determining eligibility for noncash Medicaid recipients was using an income or resource standard or methodology that was less restrictive than the applicable cash assistance standard or methodology. The Secretary was directed to report to Congress within 12 months of enactment on the impact on States and recipients of applying income and resources standards and methodologies under the cash assistance programs to noncash eligibles. The moratorium was to run until 18 months after submission of the report.

Public Law 100–93 clarified that the moratorium applied to any State Medicaid plan change submitted to the Secretary either before or after enactment of DEFRA whether or not approved, disapproved, acted on or not acted on. The law further provided that noncash recipients included noncash categorically needy recipients. It also specified that during the moratorium period an institutionalized person could sell his home in the same manner that was in effect at the beginning of the moratorium.

Public Law 100–360 provided, retroactive to October 1, 1982, that States have the flexibility to establish income and resource methodologies under medically needy, optional categorically needy, and under the "209(b)" option that are less restrictive, i.e. more generous, than those applied in the corresponding cash program.

D. MEDICAID COVERAGE OF HOME CARE FOR CERTAIN DISABLED CHILDREN

TEFRA allowed States to extend Medicaid coverage to certain disabled children under age 18 who were living at home and would be eligible for SSI (and therefore Medicaid) if they were institutionalized. The State was required to determine that (a) the child required the level of care provided in an institution; (b) it was appropriate to provide such care outside the facility; and (c) the cost of the care at home was no more than institutional care.

E. WORKING DISABLED

OBRA86 required States to continue Medicaid coverage for disabled persons with severe impairments who lost their eligibility for cash assistance because of earnings from work. A "qualified severely impaired individual" was one who: (a) was under 65; (b) in the month preceding the first month this provision applied, received cash assistance benefits or special benefits under Section 1619 of the Social Security Act; and (c) received Medicaid benefits. Further such individual: (a) had to continue to be blind or have a disabling physical or mental impairment; (b) had to meet, except for earnings, all other requirements for SSI eligibility; and (c) would have been seriously inhibited from continuing work in the absence of Medicaid coverage; and (d) did not have earnings that would be sufficient to provide a reasonable equivalent of the Medicaid, SSI or publicly funded attendant care benefits that would be available if he did not work. (This provision paralleled the section in Public Law 99-643, the SSI Improvement Amendments of 1986 which revised and extended on a permanent basis the authority contained in Section 1619 of the Social Security Act).

F. HOMELESS

Homelessness does not automatically qualify an individual for Medicaid. However, OBRA86 clarified that if an individual was otherwise qualified, States or localities could not impose any residence requirement which excluded from Medicaid an individual who resided in the State, regardless of whether the residence was maintained permanently or at a fixed address.

G. ALIENS

OBRA86 specified that Federal matching payments were not available for State expenditures for aliens who were not lawfully admitted for permanent residence or permanently residing in the U.S. under color of law (e.g. certain aliens admitted pursuant to the discretionary authority of the Attorney General). An exception was made for services provided to an individual who was otherwise eligible for Medicaid and had an emergency medical condition, including emergency labor and delivery.

The Immigration Reform and Control Act of 1986 (Public Law 99-603) provided that aliens who lived in the country continuously since January 1, 1982 could apply for legalization. If their status was adjusted to lawful temporary resident (LTR) status they were immediately eligible for Medicaid (provided they met the appropriate financial and categorical criteria) only if the following conditions were met. They had to be under 18, a Cuban-Haitian entrant, or aged, blind, or disabled as defined under the SSI program. A LTR alien, meeting the appropriate financial and categorical requirements but not falling into one of these groups, was only eligible for emergency services or services for pregnant women. These persons could be eligible for the full range of Medicaid benefits beginning 5 years after they were granted LTR status.

H. PROVISIONS AFFECTING ELIGIBILITY FOR NURSING HOME BENEFITS

1. MODIFICATIONS IN LIEN AND TRANSFER OF ASSETS PROVISIONS

TEFRA modified prior law provisions pertaining to liens and transfer of assets. TEFRA permitted States to impose liens on real property of institutionalized Medicaid beneficiaries who the State determined, after notice and opportunity for a hearing, were reasonably likely to remain in a nursing home for the remainder of their lives. States were not permitted to impose a lien on the home of a beneficiary if the spouse, child under 21, disabled child, or sibling with an equity interest was residing in the home. The lien dissolved if the individual was discharged from the institution and returned home.

TEFRA specified that a State could not foreclose on a lien until the beneficiary voluntarily sold his property or until after his death. Foreclosure actions could not be taken until after the death of the surviving spouse and/or any children who were blind or disabled; protection was offered for additional family members where the lien had been imposed on the individual's home.

TEFRA also expanded existing transfer of assets provisions. It permitted States, subject to certain exceptions, to deny Medicaid eligibility for 24 months to institutionalized persons who, within 24 months prior to application for Medicaid, disposed of their homes for less than fair market value even though such disposal would not have made them ineligible for SSI. States could deny eligibility for a longer period if the uncompensated value was greater than 24 months. They were required to set a shorter period if the uncompensated value was less than 24 months.

Public Law 100–360 provided effective with respect to transfers occurring on or after July 1, 1988, that States were required to determine, at the time of application for Medicaid benefits, whether an institutionalized individual had disposed of resources for less than fair market value within the preceding 30 months. Where such a disposal occurred, States were required to delay Medicaid eligibility for a number of months equal to the quotient of the uncompensated value of the transferred assets divided by the cost of nursing home care. Public Law 100–360 further repealed existing SSI transfer-of-assets provisions with respect to cash assistance benefits; the new Medicaid rules were to be applied in considering an individual's eligibility for Medicaid if and when such individual entered a medical institution or nursing facility.

2. TREATMENT OF POTENTIAL PAYMENTS FROM MEDICAID QUALIFYING TRUSTS

COBRA added potential payments from "Medicaid qualifying trusts" to the list of income and resources available to an individual and therefore considered in determining eligibility. A qualifying trust was defined as one which had been established (other than by a will) by an individual under which the individual could be the beneficiary of part or all of the payments from the trust and the distribution of such payments was determined by one or more trustees who were permitted to exercise any discretion with respect to the amount distributed to the individual. Distributions were to be considered available to the individual whether or not they were actually made.

OBRA86 clarified that the COBRA provision relating to the treatment of income from certain trusts did not apply to such trusts if they were established before April 7, 1986, solely for the benefit of residents of ICFs/MR.

3. PERSONAL NEEDS ALLOWANCE

OBRA87 raised the monthly personal needs allowance for nursing home residents from $25 to $30.

4. PROTECTION OF INCOME AND RESOURCES OF COUPLE FOR MAINTENANCE NEEDS OF COMMUNITY SPOUSE

Public Law 100–360 included provisions intended to protect against so-called spousal impoverishment. The law provided that after an institutionalized individual had established eligibility for Medicaid, the State would be required to allow the community spouse to receive a certain portion of the institutionalized spouse's income. The amount must be sufficient to raise the community spouse's monthly income to at least: 122 percent of the poverty level for a couple, effective September 30, 1989; 133 percent of such level, effective July 1, 1991, and 150 percent of such level, effective July 1, 1992. The monthly protected income could not exceed $1,500, except where a higher level was determined necessary by a fair hearing or court order.

Public Law 100–360 also included provisions relating to protection of resources. Effective September 30, 1989, States are required, in making eligibility determinations for institutionalized persons, to total all nonexempt resources held by either the community spouse or the institutionalized spouse and divide them equally. States would be required to protect a minimum of $12,000 for the community spouse; they could raise the minimum to $60,000. The community spouse's share could not exceed $60,000, except where a higher amount was provided under a fair hearing or court order.

5. BEGINNING DATE OF OPTIONAL COVERAGE FOR INDIVIDUALS IN MEDICAL INSTITUTIONS

COBRA clarified that Medicaid payment could begin at the beginning of any 30 consecutive day period of institutionalization in the case of institutionalized persons for whom a State applied a special income standard.

II. SERVICES

Recent legislation added nurse midwife services to the list of services States are required to offer and added the following to the list of optional Medicaid services: hospice care, case management, and home respiratory care for ventilator dependent persons. Further, requirements relating to beneficiary cost-sharing were substantially revised.

A. Nurse Midwife Services

ORA80 required States to provide coverage for services furnished by a nurse midwife that he or she is legally authorized to perform whether or not he or she is under the supervision of, or associated with a physician or other health care provider.

B. HOSPICE BENEFITS

COBRA allowed States to cover hospice care as an optional service for terminally ill individuals who elected to receive hospice care and waived their eligibility for certain other benefits. The definitions of hospice care and hospice program were the same as those used under Medicare, except States could define the length of coverage.

OBRA86 clarified rules for payment with respect to an individual, who was eligible for both Medicare and Medicaid, resided in a SNF or ICF, was having Medicaid payments made on his/her behalf for such institutional services, elected Medicare hospice coverage, and resided in a State which did not cover hospice services pursuant to the COBRA provision. The SNF or ICF and the hospice must have entered into a written agreement under which the program took full responsibility for the professional management of the individual's hospice care and the facility agreed to provide room and board. In such circumstances, the State was directed to pay the hospice program an amount equal to the amounts allocated under Medicaid for room and board in a SNF or ICF, plus applicable coinsurance amounts.

OBRA87 provided that for Medicaid services only, a hospice could exclude inpatient care provided to AIDS patients from the law's 20 percent inpatient day limit.

C. CASE MANAGEMENT

COBRA added targeted case management services to the list of covered Medicaid services and allowed States to cover such services without regard to the statewideness or comparability requirements. OBRA86 provided that States were allowed to limit the provision of services to individuals with acquired immune deficiency syndrome (AIDS) or with AIDS-related conditions, or with either. A State could also limit the provision of case management services to persons with chronic mental illness.

D. TECHNOLOGY-DEPENDENT PERSONS

COBRA required the Secretary to establish a task force concerning alternatives to institutional care for technology dependent children. The task force was required to report to the Secretary and the Congress within 2 years of enactment.

OBRA86 permitted States to provide optional coverage of respiratory care services in the home for individuals who were: (a) medically dependent on a ventilator for life support at least 6 hours a day; (b) who were so dependent at least 30 days as inpatients; (c) had adequate social support services at home; (d) who wished to be cared for at home; and (e) who in the absence of such care would require respiratory care on an inpatient basis for which Medicaid would pay.

E. ORGAN TRANSPLANTS

COBRA prohibited Federal matching for organ transplant procedures unless: (1) the State plan provided written standards for coverage; and (2) the standards provided that similarly situated individuals were treated alike and any restrictions placed on providers who could provide the care were consistent with access to high quality care.

OBRA87 specified that if a State covered organ transplants, such services had to be sufficient in amount, duration, and scope to achieve their purpose.

F. Copayments by Medicaid Recipients

TEFRA modified prior cost-sharing requirements by permitting States to impose cost-sharing charges for all persons for all services with certain exceptions. States were prohibited from imposing such charges on services provided to children under age 18, services related to pregnancy, services provided to inpatients of SNFs and ICFs, family planning or emergency services, and categorically needy HMO enrollees. TEFRA specified that if a State imposed cost-sharing charges they had to be nominal in amount. The Secretary could waive the nominality requirement in the case of nonemergency services in emergency rooms where the State had established, to the satisfaction of the Secretary, that alternative sources of nonemergency services were actually available and accessible.

III. REIMBURSEMENT

The major reimbursement changes incorporated in recent legislation related to calculation of payment rates for institutional services. Several laws addressed the calculation of rates for hospitals serving a disproportionate number of low income patients.

A. Reimbursement of Hospitals

Prior to enactment of OBRA81, States were required to reimburse hospitals on a reasonable cost basis as then defined under Medicare unless they had approval to use an alternative payment method. OBRA81 required instead that State payments for inpatient hospital services be reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to meet State and Federal laws, regulations, and quality and safety standards. The law required States, in developing their payment rates to take into account the situation of hospitals serving a disproportionate number of low income patients. Further, the payment rates were to be sufficient to assure that Medicaid patients had reasonable access (taking into account geographic location and reasonable travel time) to services of adequate quality.

COBRA required the Secretary to submit a report to Congress by October 1, 1986 which (1) described the methodology used by States to take into account the situation of hospitals serving a disproportionate number of low income patients; and (2) identified the hospitals that received a disproportionate share adjustment and specified the proportion of low income and Medicaid patients at such hospitals.

OBRA86 provided that nothing in the Medicaid law was to be construed as authorizing the Secretary to limit the amount of payment adjustments that could be made under a State Medicaid plan with respect to hospitals serving a disproportionate number of low-income patients with special needs.

OBRA87 implemented the requirement that States take into account the situation of hospitals serving a disproportionate number of low income patients with special needs. It required States, by July 1, 1988, to submit a Medicaid plan amendment that defined disproportionate share hospitals and provided for an appropriate increase in the payment rate for inpatient services provided by these hospitals. A hospital would be deemed a disproportionate share hospital if: (a) its Medicaid inpatient utilization rate was in excess of one standard deviation above the mean rate for the State; or (b) it had a low-income utilization rate of 25 percent. Payment adjustments would be phased in over a 3 year period.

Public Law 100–360 provided that States which imposed durational limits on Medicaid payments for inpatient hospital services must establish exceptions to such limits in the case of medically necessary inpatient services received by an infant (up to age 1) in a disproportionate share hospital. The law further provided that if a State pays for inpatient hospital services on a prospective basis, it must provide for an outlier share adjustment for disproportionate share hospitals providing medically necessary inpatient services for infants.

B. Reimbursement of Skilled Nursing and Intermediate Care Facilities

Prior to the enactment of ORA80, States were required to pay SNFs and ICFs on a reasonable cost-related basis in accordance with methods and standards developed by the State on the basis of cost-finding methods approved and verified by the Secretary. ORA80 required instead that States reimburse such facilities at rates that are reasonable and adequate to meet the cost which must be incurred by efficiently and economically operated facilities in order to provide care in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

OBRA87 contained major nursing home reform provisions for both Medicare and Medicaid. Effective October 1, 1990, the current law distinction between SNFs and ICFs will be eliminated as will the requirement that States pay less for ICF than for SNF services.

C. Flexibility in Setting Payment Rates for Hospitals Furnishing Long-Term Care Services

DEFRA modified the requirements pertaining to establishment of payment rates for small rural hospitals furnishing long-term care services by permitting States to use the special payment rates or alternatively the same criteria generally applicable for payment of long-term care services.

D. Revaluation of Assets

DEFRA specified that Medicare payments to providers could not be increased to reflect higher capital costs that resulted solely from the sale of a facility. Capital costs to the new owner were to be the lesser of the historical cost (less depreciation) or the acquisition cost. Medicaid payments were subject to similar limits. COBRA amended the Medicaid provision to allow a State's aggregate cost payments to SNFs and ICFs to reflect increases in valuation due to their change in ownership, subject to certain limits.

E. Removal of Medicaid Reasonable Charge Limitations

OBRA81 removed the prior law requirement that payment for physicians' and certain other services could not exceed the reasonable charge levels as defined under Medicare.

F. Treatment of Educationally Related Services

Public Law 100-360 specified that Federal matching funds are available for the cost of services which are furnished in connection with the Education of the Handicapped Act (provided the services are covered under a State's Medicaid program). Services which could be covered under Medicaid are either those furnished to a handicapped child pursuant to a child's individual education program established under the Act or services furnished to a handicapped infant or toddler which are included in the child's individualized family service plan adopted pursuant to that Act.

IV. ALTERNATIVE DELIVERY SYSTEMS

OBRA81 included several provisions designed to give States increased flexibility in the design and implementation of their Medicaid plans. The most significant of these were two waiver authorities: the freedom-of-choice waiver and the home and community based services waiver.

During the 1981-87 period the Congress also approved a number of waivers for individual States to test various alternative delivery approaches.

A. Inapplicability of Freedom-of-Choice and Other State Plan Requirements

OBRA81 authorized the Secretary to waive certain State plan requirements as might be necessary to achieve certain program purposes. These so-called "2175 waivers" were to enable a State to:

(1) implement a case management system or specialty physicians services arrangement which restricted the provider from or through whom individuals could obtain primary care services (other than under emergency circumstances), so long as the restriction did not substantially impair access to services of adequate quality;

(2) allow a locality to act as a central broker in assisting individuals in selecting among competing health care plans;

(3) share with recipients any cost savings (through provision of additional services) resulting from the use by the recipient of more cost-effective medical care; and

(4) restrict the provider from or through whom an individual could obtain services (other than in emergency circumstances) to providers or practitioners who complied with State plan reimbursement, quality, efficiency, and utilization standards, so long as the restriction did not discriminate among classes of

providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services.

TEFRA deleted the authority of the Secretary, under the "2175 waiver provision", to waive the requirements for HMOs and other prepaid entities contracting on a risk basis to provide Medicaid services.

B. WAIVERS TO PROVIDE HOME AND COMMUNITY-BASED SERVICES

OBRA81 authorized the Secretary to waive Federal requirements to enable a State to provide home and community-based services (other than room and board), pursuant to a written plan of care, to individuals who would otherwise require SNF or ICF services which would be reimbursed by Medicaid. Services which could be provided under these "2176 waivers" (in addition to those otherwise authorized under Medicaid) included case management, homemaker/home health aide and personal care services; adult day health; habilitation services; respite care; and other services requested by the State and approved by the Secretary.

The Secretary could not approve a "2176 waiver" unless the State provided the following assurances:

—Necessary safeguards were taken to protect the health and welfare of individuals receiving services and to assure financial accountability for expended funds;

—The State would provide an evaluation of the individual's need for SNF or ICF care;

—Individuals determined likely to require SNF or ICF care would be informed of the feasible alternatives available at their choice under the waiver;

—The average per capita expenditure for individuals provided services under the waiver would not exceed the average per capita amount which would have been expended for such individuals if the waivers had not been in effect;

—The State would annually provide information to the Secretary on the impact of the waiver on the type and amount of medical assistance provided and on the health and welfare of recipients.

Amendments to the original 2176 waiver authority generally addressed issues raised by implementing regulations and/or administration of the program by HCFA. The following were the major COBRA modifications:

—The law clarified that the estimated per capita expenditure amount for medical services in any fiscal year could not exceed 100 percent of the average per capita expenditure that the State reasonably estimated would have been incurred in that year if the waiver had not been approved. The Secretary was prohibited from requiring that actual total expenditures under a 2176 waiver could not exceed the approved estimates for these services. The Secretary was prohibited from denying Federal matching payments under the waiver on the grounds that a State failed to limit actual total expenditures to the approved estimates. Further, States were allowed, in estimating average per capita expenditures for physically disabled individuals in

SNFs and ICFs to use only expenditures associated with this group of patients.

—States could establish, for individuals receiving waivered services in the community, higher maintenance needs allowances than the maximum amounts specified in regulations in effect on July 1, 1985.

—The Secretary was required, upon the request of a State, to extend for a minimum of 1 year and a maximum of 5 years any 2176 waiver that expired on or after September 30, 1985 and before September 30, 1986. The Secretary was required to renew waivers for additional 5-year, rather than 3-year periods.

—The law defined covered habilitation services, with respect to individuals receiving such services after discharge from a SNF or ICF, as services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

OBRA86 made a number of additional changes to the 2176 provisions including:

—Eligibility for home and community-based services was extended to all individuals who, but for the provision of such services, would require the level of care provided in a hospital, SNF or ICF, the cost of which would be reimbursed under Medicaid.

—In the case of a waiver that applied only to individuals with a particular illness or condition, the State could estimate the average per capita expenditure associated with this group of persons and not the expenditures associated with other individuals in hospitals, SNFs or ICFs.

—The following additional services were added under the waiver authority for the chronically mentally ill: day treatment or other partial hospitalization services; psychosocial rehabilitation services; and clinic services (whether or not furnished in a facility).

OBRA87 raised the limit on the number of persons who could be covered under a model home and community based services waiver to 200. Public Law 360 clarified that the Secretary could not limit the number of persons covered under a waiver to under 200 persons.

OBRA87 specified that in the case of a waiver that applied only to persons with developmental disabilities requiring ICF/MR services, the State could estimate the average per capita expenditure associated with just this group of persons. Public Law 100–360 specified that this may be done without regard to the availability of beds for such inpatients.

C. Long-Term Care Services for the Elderly

OBRA87 established a new waiver authority, separate from the 2176 waiver authority. Enactment of this "1915(d) waiver" was in response to an issue which had arisen in connection with implementation of the 2176 authority. To meet the law's requirement that the average per capita expenditures under 2176 waiver programs not exceed average per capita expenditures that would be incurred in the absence of the waiver, HCFA required States to estimate the number of individuals who would otherwise be served in a Medicaid nursing home bed. HCFA used this estimate as a ceiling on the number of persons who could be served under the waiver. States that restricted the supply of nursing home beds were therefore limited in the number of persons they could enroll under the waiver.

OBRA87 therefore established a new waiver authority that allowed States, on a budget neutral basis, to provide a mix of home and community-based and institutional services to the elderly at risk of nursing home care. The budget neutrality formula limited States electing the waiver in 1988 and 1989 to a maximum 7 percent rate of growth in their institutional and noninstitutional long-term care outlays under Medicaid, compounded annually. The Secretary was required to promulgate, by October 1, 1989, indices for projecting increases in institutional and noninstitutional long-term care costs, as well as State-specific projections of increases in the number of residents over age 75. Upon promulgation, the test for budget neutrality would be the greater of: (1) the sum of the percentages yielded by these indices, and (2) 7 percent, compounded annually. Public Law 100–360 modified the provision by specifying that the State specific projections were for persons over 65; it required the Secretary, by October 1, 1989, to develop a method of projecting the increases for persons over 75.

D. BOARDER BABIES

The term boarder babies is used to apply to newborn babies, infected with AIDS or drug dependent, who are left at the hospital because their mothers are unable to care for them. Public Law 100–360 authorized waivers from certain State plan requirements (comparability and statewideness) for States to provide part or all of the cost of specified services to certain children who would otherwise be likely to require hospital or nursing home care. Services which could be covered under a waiver are nursing care, respite care, physicians' services, prescribed drugs, medical devices and supplies, transportation services, and such other services requested by the State. Children who could be covered under such a waiver are those under age 5 who at the time of birth were infected with or tested positively for AIDS, had AIDS, or at the time of birth were dependent on heroin, cocaine, or phencyclidine. These children must also be ones for whom adoption or foster care assistance is or will be made available. States are required to provide certain assurances including an assurance that per capita expenditures will not exceed those which would have been spent in the absence of a waiver.

E. PROVISIONS RELATING TO HEALTH MAINTENANCE ORGANIZATIONS (HMOS) AND OTHER PREPAID HEALTH PLANS

OBRA81 permitted States to enter into prepaid or other risk arrangements with entities other than federally qualified HMOs, provided that such entities met certain requirements. The provision raised the existing ceiling on Medicare and Medicaid beneficiaries in HMOs from 50 percent to 75 percent of enrollment; the Secretary could waive this requirement in the case of public HMOs if he determined special circumstances warranted and the entity was taking reasonable efforts to enroll non-Medicare/Medicaid beneficiaries. The law required that enrollees under a risk arrangement be permitted to disenroll without cause on one month's notice. Further, the law added additional contract requirements relating to financial accountability, nondiscrimination on the basis of health status, termination provisions, and payment for emergency services furnished elsewhere. States were permitted to enter arrangements with Federally qualified HMOs under which minimum enrollment periods of up to 6 months would be established, i.e. eligibility would be guaranteed even if the individual lost Medicaid eligibility during the period.

DEFRA permitted the Secretary to waive or modify the 75 percent enrollment requirement in the case of a nonprofit federally qualified HMO in an underserved area which had at least 25,000 enrollees and which had previously received an enrollment waiver.

DEFRA also permitted States to require Medicaid beneficiaries who enrolled in HMOs meeting certain requirements to remain in the HMO for up to 6 months unless the beneficiary had good cause to disenroll earlier. COBRA extended the continuation of benefits and restricted disenrollment provisions to certain federally funded community, migrant, and Appalachian health centers.

COBRA also provided that where a health insuring organization (HIO) arranged with other providers (through subcontract or otherwise) for the delivery of services to Medicaid beneficiaries, it was subject to the requirements applicable to HMOs or other prepaid entities. This provision applied even though the HIO itself did not itself deliver services.

OBRA86 required States to provide for an annual independent review of Medicaid services provided or arranged by each HMO, HIO, or other prepaid plan with which the State had entered a risk-based contract. The State could select a PRO or private accreditation body to perform this function. OBRA87 provided that the 75 percent Federal matching rate for the cost of independent quality review of HMO care applied both to PROs and to other qualified review organizations.

OBRA86 required any HMO that was not a federally qualified HMO and was contracting with a State to provide services to Medicaid beneficiaries on a capitated or risk basis to report to the State a description of transactions between the organization and party in interest. Transactions required to be reported included: any sale, exchange or leasing of property; any furnishing for consideration of goods, services, or facilities (but not employees salaries); and any loans or extensions of credit. The information would be made available upon request to the Secretary, Inspector General, the Comptroller General, and the organization's enrollees. The Secretary was required to give prior approval of contracts in excess of $100,000 between States and entities contracting to provide services to Medicaid beneficiaries on a capitated or risk basis.

OBRA86 further provided for the imposition of civil monetary penalties for entities, contracting on a risk basis with States, under the following circumstances. Penalties would be imposed if the entity failed to provide required medically necessary items and services and such failure adversely affected the patients. OBRA87 expanded the acts that would be subject to penalties to include imposition of excess premiums, acts to expel or refuse to reenroll individuals in violation of the law, practices which would reasonably be expected to have the effect of denying or discouraging enrollment of persons whose medical condition indicated the need for substantial future medical services, and misrepresenting or falsifying information. OBRA (1987) authorized suspensions of enrollments and payments in addition to civil monetary penalties. Public Law 100–360 incorporated technical modifications and increased the possible amount of civil monetary penalties under this section. Further, the law provided for a denial of Federal payments (in lieu of the suspension provisions) in cases where the Secretary determined a violation existed; the denial would remain in effect until the Secretary was satisfied that the basis for the determination was corrected.

V. ADMINISTRATION

Recent legislation has included a number of provisions targeted toward improving the accuracy of eligibility determinations, improving collection of third party liabilities, and strengthening utilization review activities.

A. Eligibility Determinations

1. QUALITY CONTROL/TARGET ERROR RATES

TEFRA deleted provisions, incorporated in the 1980 Appropriations Act, pertaining to target error rates for eligibility determinations and penalties for failure to fall below these levels. It established a 3 percent target error rate for erroneous excess payments beginning after March 30, 1983. It provided for the application of prospective fiscal sanctions for the 6-month period beginning April 1, 1983 and annually thereafter. The Secretary was provided discretion in applying the penalty, in whole or in part, for a State which made a good faith effort to meet the 3 percent target.

COBRA required the Secretary to conduct a study of AFDC and Medicaid quality control programs. The Secretary was required to contract with the National Academy of Sciences to conduct a concurrent independent study for the same purpose. When the studies were completed, the Secretary was required to restructure these quality control programs and establish criteria for adjusting fiscal sanctions previously imposed.

OBRA87 prohibited the imposition of fiscal sanctions prior to July 1, 1988.

2. INCOME AND ELIGIBILITY VERIFICATION SYSTEM

DEFRA required States to have an income and eligibility verification system for use in administering Medicaid and other specified programs. The programs were required to request and make use of Internal Revenue Service unearned income and quarterly wage information. OBRA86 clarified that the requirement that the use of such information be targeted toward the most productive uses, did not require States to use the information to verify the eligibility of all recipients. The Immigration Reform and Control Act of 1986 required, effective October 1, 1988, all Medicaid applicants to declare in writing, under penalty of perjury, that they were a citizen or national of the U.S. or an alien in a satisfactory immigration status. In addition, States were required to verify with the Immigration and Naturalization Service, the immigration status of all aliens applying for Medicaid. Public Law 100–360 exempted illegal aliens receiving treatment for emergency medical conditions from this requirement.

3. PRESUMPTIVE ELIGIBILITY

OBRA86 permitted States to make ambulatory prenatal care available to pregnant women for a presumptive period of eligibility. The period would begin on the date on which a qualified provider determined (on the basis of preliminary information) that the family income fell below the applicable Medicaid standard. The period would end on the earlier of: (a) the day on which a determination was made on the application by the State agency; (b) 45 days after the provider made the determination; or (c) 14 days after the preliminary determination, if the woman did not file an application.

B. INAPPLICABILITY OF CERTAIN STATE PLAN REQUIREMENTS

OBRA81 permitted a State, for a reasonable period of time, to (1) require individuals who overutilized services to use particular providers (sometimes referred to as "lock-in"); and (2) limit the participation of providers, which the State found (after notice and opportunity for a hearing) to have, in a significant number or proportion of cases, abused the program (sometimes referred to as "lock-out"). A restriction was permitted provided individuals eligible for a service had reasonable access (taking into account geographic location and travel time) to such services of adequate quality. The legislation also permitted States to enter into competitive bidding or other arrangements for the purchase of laboratory services or medical devices for Medicaid recipients.

C. CLAIMS PROCESSING

Medicaid requires States to take reasonable measures to ascertain the legal liability of third parties (such as private insurers) to pay for services that Medicaid would otherwise have to pay for. If Medicaid has made payment for such care, the State is required to seek recovery from the third party. OBRA81 modified the third-party recovery requirement by specifying that it only applied to cases where the amount of recovery could reasonably be expected to exceed the cost of taking action.

DEFRA mandated States to require Medicaid applicants to assign to States their right to payment for medical support (as specified by a court or administrative order) and other medical care.

COBRA made a number of additional modifications to the third party recovery requirements including: (a) specifying certain State actions for meeting the requirement that States take reasonable measures for ascertaining the legal liability of third parties; (b) requiring the Secretary to develop performance standards for assessing States' third party liability collection efforts which were to be integrated with and monitored as part of the Secretary's review of each States Medicaid Management Information System (MMIS); and (c) requiring individuals, as a condition of eligibility, to cooperate with the State in identifying, and providing information to assist the State in pursuing, any liable third parties unless such individual had good cause for refusing to cooperate.

D. Utilization Review/Peer Review

1. RECERTIFICATION OF SNF AND ICF PATIENTS

States are required to have an adequate utilization control program; as part of this program, physicians are required to recertify the continuing need for SNF and ICF stays. DEFRA modified existing recertification requirements. It required recertifications of SNF patients 30, 60, and 90 days after initial certification and every 60 days thereafter. ICF recertifications were required 60 days, 180 days, 12 months, 18 months, and 24 months after initial certification and every 12 months thereafter. OBRA87 provided that these requirements would be eliminated when nursing home reform provisions are fully implemented on October 1, 1990.

2. PEER REVIEW ORGANIZATION PROGRAM

TEFRA provided for the establishment of a peer review organization (PRO) program. PROs are charged with the review of necessity, appropriateness, and quality of services provided under Medicare. TEFRA authorized the States to contract with PROs for Medicaid review and authorized 75 percent Federal matching for such purpose.

3. STATE UTILIZATION REVIEW SYSTEMS

OBRA86 temporarily prohibited the Secretary from issuing final regulations requiring States to implement second surgical opinion programs (SSOPs) or hospital preadmission review programs. The prohibition would end 180 days after the submission of a report to Congress, based on a representative sample of States, on: (1) high cost or high volume procedures; (2) payment rates and aggregate payments for such procedures; (3) utilization rates of these procedures among Medicaid and non-Medicaid populations; (4) number of physicians performing these procedures and the number providing second opinions; and (5) steps States with mandatory SSOPs took to avoid access problems, particularly in rural areas. The report was to include a list of surgical procedures that the Secretary believed should be included in a mandatory SSOP. The report is due by October 1, 1988. By January 1, 1990, the Secretary must submit a report to Congress examining the utilization of selected medical treatments and surgical procedures by Medicaid beneficiaries to assess the appropriateness, necessity and effectiveness of such treatments and procedures. Public Law 100-360 specified that the report due January 1, 1990 was to be an interim report, with a final report due by January 1, 1992.

VI. FINANCING

Financing amendments enacted since 1981 can be classified into one of three categories: temporary reductions in Federal matching payments, calculation of the Federal Medical Assistance Percentage, and increasing the payment limits for the territories.

A. REDUCTION IN MEDICAID PAYMENTS TO STATES AND OFFSET FOR MEETING FEDERAL MEDICAID EXPENDITURE TARGETS

OBRA provided for reductions in Federal Medicaid payments to States. The amount of Federal matching payments to which a State was otherwise entitled was to be reduced by 3 percent in fiscal year 1982, 4 percent in fiscal year 1983, and 4.5 percent in fiscal year 1984. A State could lower the amount of its reduction by one percentage point for each of the following: (1) operating a qualified hospital cost review program; (2) sustaining an unemployment rate exceeding 150 percent of the national average; or (3) demonstrating recoveries from fraud and abuse activities (and with respect to fiscal year 1982, third party recoveries) equal to 1 percent of Federal payments. A State was entitled to a dollar for dollar offset in its reduction if total Federal Medicaid expenditures in a year fell below a specified target amount; in no case could the amount recovered exceed the total amount of reductions. The legislation also included several amendments designed to give States increased flexibility in implementing their Medicaid programs.

B. FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)

OBRA81 required the Comptroller General, in consultation with the Advisory Committee for Intergovernmental Relations, to conduct a study of the Federal Medical Assistance Percentage.

COBRA required an annual, rather than biennial calculation of the FMAP beginning with fiscal year 1987. OBRA87 provided that the change to the annual calculation would not apply to State Medicaid programs, in fiscal year 1987 only, if the State would be adversely affected by the change.

C. PAYMENTS TO TERRITORIES

OBRA81 increased, effective fiscal year 1982, the annual ceilings on Federal payments to the territories. The ceiling for Puerto Rico was increased from $30 million to $45 million; the ceiling for the Virgin Islands was increased from $1 million to $1.5 million; and the ceiling for Guam was increased from $0.9 million to $1.4 million. The law also established a ceiling for the Northern Mariana Islands at $350,000.

TEFRA authorized, effective fiscal year 1983, Medicaid coverage in American Samoa, subject to the same 50 percent matching rate applicable for other territories, and established an annual expenditure limitation at $750,000. TEFRA gave the Secretary broad authority to waive or modify existing Medicaid requirements with respect to this jurisdiction.

DEFRA increased the ceilings, effective fiscal year 1984, as follows: Puerto Rico, $63.4 million; Virgin Islands, $2.1 million; Guam,

$2.0 million; Northern Mariana Islands, $550,000; and American Samoa, $1.15 million.

OBRA87 increased the ceilings as follows: Puerto Rico, $73.4 million in fiscal year 1988, $76.2 million in fiscal year 1989, and $79.0 million in fiscal year 1990 and subsequent¶ years; Virgin Islands, $2.43 million in fiscal year 1988, $2.515 million in fiscal year 1989, and $2.6 million in fiscal year 1990 and subsequent years; Guam,$2.320 million in fiscal year 1988, $2.41 million in fiscal year 1989 and $2.5 million in fiscal year 1990 and subsequent years; Northern Mariana Islands, $636,700 in fiscal year 1988, $693,350 in fiscal year 1989, and $750,000 in fiscal year 1990 and subsequent years; and American Samoa, $1.33 million in fiscal year 1988, $1.39 million in fiscal year 1989, and $1.45 million in fiscal year 1990 and subsequent years.

OBRA87 also permitted the Secretary to waive most Medicaid requirements with respect to the Northern Mariana Islands.

VII. QUALITY OF INSTITUTIONAL LONG-TERM CARE SERVICES

Congress has enacted several amendments designed to improve the quality of services provided to residents in long term care facilities. Of particular importance were the nursing home reform provisions incorporated in OBRA87.

A. Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

COBRA added a new section to the law dealing with ICF/MR correction and reduction plans. The section specified that if the Secretary found that an ICF/MR had substantial deficiencies which did not impose an immediate threat to the resident's health and safety, the State could elect to submit either a written correction plan or reduction plan. The correction plan had to identify deficiencies found during a validation survey and provide a timetable for correcting all staffing and/or physical plant deficiencies within 6 months. A reduction plan had to provide for permanently reducing the number of certified beds, within a maximum of 36 months, in order to permit any noncomplying buildings (or distinct part thereof) to be vacated and any staffing deficiencies to be corrected. OBRA87 specified that the implementing regulations were to be effective as if promulgated on the effective date of COBRA (April 7, 1986).

B. Review of SNF and ICF Services

DEFRA made consistent state plan requirements for medical review for SNFs and independent professional review for ICFs.

C. Nursing Home Quality Improvements

OBRA87 contained major nursing home reform provisions for both Medicare and Medicaid. Effective October 1, 1990, all nursing facilities participating in Medicaid will have to meet a single set of requirements pertaining to the provision of services, residents' rights, administration and other matters.

The law established a new process, effective October 1, 1990, for State and Federal monitoring of nursing facility compliance with the Medicaid requirements. The Secretary will be responsible for determining the compliance of State nursing facilities; States will be responsible for determining the compliance of all other nursing facilities. The Secretary will conduct on-site validation surveys of at least 5 percent of the facilities surveyed by the State each year.

In general, certification will be based on a two-step survey process—an unannounced standard survey which would occur, on the average, at least annually and an extended survey for facilities found during a standard survey to have provided substandard quality care.

The law expanded the remedies available to both the Secretary and the States for the purposes of deterring and sanctioning noncompliance with Medicaid requirements. The Secretary's new remedies were effective January 1, 1988, with respect to current requirements for SNFs and ICFs; they will apply with respect to compliance by nursing facilities with the new requirements when those take effect October 1, 1990. States are required to have the new remedies in place no later than October 1, 1989. The law detailed intermediate remedies that could be taken if a facility's deficiencies did not immediately jeopardize the health or safety of residents.

No changes were made in the current law requirements for ICFs/MR or institutions for mental diseases. However, effective January 1, 1989, each State must have in effect a preadmission screening program for all mentally ill or mentally retarded individuals to determine whether placement in a SNF or ICF is appropriate. Federal matching payments will not be available for persons not found to need placement. As of April 1, 1990, States must have reviewed all mentally ill or mentally retarded individuals in nursing facilities to determine whether continued placement is appropriate, and must arrange for the safe and orderly discharge and active treatment of residents for whom continued placement is inappropriate.

VIII. FRAUD AND ABUSE

OBRA81 authorized the Secretary to assess a civil monetary penalty of up to $2,000 for fraudulent claims under Medicaid and Medicare and to impose an assessment of twice the amount of the fraudulent claim, in lieu of damages.

OBRA86 provided for a civil monetary penalty of $2,000 per patient if a hospital (or effective April 1, 1989, an entity delivering services on a risk basis) knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services to Medicaid patients who are under the direct care of the physician. The Secretary was required to report to Congress by January 1, 1988 on incentive arrangements offered by HMOs and competitive medical plans. OBRA87 delayed application of the provision to risk based entities to April 1,1990.

OBRA86 contained several additional modifications to the existing civil monetary penalty and exclusion provisions applicable to both Medicare and Medicaid. It specified that when an individual had a prior conviction of a Federal crime charging fraud or false statements, and the current proceedings involved the same transactions, the individual was prevented from denying the elements affirmed in the previous trial. It authorized the official conducting a hearing to impose sanctions for misconduct that would interfere with the speedy, orderly, or fair conduct of a hearing. Further, the law clarified cases under which an individual would be considered convicted of a criminal offense for purposes of exclusion from the program.

The Medicare and Medicaid Patient and Program Protection Act of 1987 was designed to protect Medicare and Medicaid beneficiaries from unfit health practitioners and to recodify and strengthen the antifraud provisions in the Social Security Act. Under the law, the Secretary was required to exclude from Medicare and required to direct States to exclude from Medicaid any individual or entity convicted of a criminal offense related to delivery of services under these programs or convicted of a criminal offense related to neglect or abuse of patients in connection with the delivery of a health care item or service. Under certain other specified circumstances, the Secretary was permitted to exclude individuals or entities from Medicare and could direct States to exclude them from Medicaid. These circumstances included: conviction of fraud in connection with a health care program; conviction relating to obstruction of an investigation of health care fraud, license revocation or suspension; exclusion or suspension under Federal or State health care program; claims for excessive charges or unnecessary services; fraud, kickbacks or other prohibited activities; failure to make required disclosures; failure to supply requested information on subcontractors and suppliers; and failure to supply payment information. The Secretary was required to specify the duration of the exclusion; mandatory exclusions were for a minimum of 5 years. A State was permitted to exclude any individual or entity from Medicaid for any reason for which the Secretary could have excluded an individual from participation in Medicare. A State had to exclude an HMO which could have been excluded from Medicare because of the conviction of the owners or managers for certain crimes or which had a substantial or contractual relationship with any individual or entity convicted of such crimes. The law also required States to have a system of reporting information with respect to formal proceedings concluded against a health care practitioner or entity by a State licensing authority. The law further clarified and consolidated civil monetary and criminal penalty provisions.

IX. ESTIMATED IMPACT OF LEGISLATION

The Congressional Budget Office estimated the impact of each of the reconciliation bills at the time of their enactment. However, the numbers *cannot* be added together. The CBO baseline estimate in a year reflects economic assumptions at the time the estimate is made. Estimates of the impact of legislative changes are compared with that baseline. Any costs or savings attributable to passage of one reconciliation bill, as well as any changes in economic assumptions, are included in the current law CBO baseline for the next fiscal year. Tables VIII-1 to VIII-7 show the CBO estimates of changes in Federal Medicaid outlays which were made at the time of enactment of the 1981-87 reconciliation bills and the Medicare Catastrophic Coverage Act.

Table VIII-1.—PUBLIC LAW 97-35, OMNIBUS BUDGET RECONCILIATION ACT OF 1981 (OBRA (1981)), CONGRESSIONAL BUDGET OFFICE ESTIMATES OF CHANGES IN MEDICAID OUTLAYS MADE AT TIME OF ENACTMENT, FISCAL YEARS 1982-84

[In millions of dollars]

	Fiscal Year 1982	Fiscal Year 1983	Fiscal Year 1984
Medicaid provisions	−$890	−$870	−$1,000
Impact of Medicare provisions	−44	−50	−52
Other	2	8	11
Total	−932	−912	−$1,041

Source: Congressional Budget Office. Unpublished tables. August 1981.

Table VIII-2.—PUBLIC LAW 97-248, TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA), CONGRESSIONAL BUDGET OFFICE ESTIMATES OF CHANGES IN MEDICAID OUTLAYS MADE AT THE TIME OF ENACTMENT, FISCAL YEARS 1983-85

[In millions of dollars]

	Fiscal Year 1983	Fiscal Year 1984	Fiscal Year 1985
Medicaid provisions:			
Copayments by Medicaid recipients	$45	$50	$56
Modification in lien provisions	165	180	200
Error rate sanctions	30	65	72
Coverage of disabled children at home	(1)	(1)	(1)
American Samoa	−1	−1	−1
Subtotal, Medicaid provisions	239	294	327
Other items:			
Impact of Medicare provisions	1	46	122
Impact of AFDC provisions	16	20	25
Impact of penalty provisions of OBRA81	0	−30	−30
Subtotal, other items	17	36	117
Total	256	330	444

[1] Negligible cost.

Source: U.S. Congress. House. Tax Equity and Fiscal Responsibility Act of 1982. Conference Report to Accompany H.R. 4961. August 7, 1982. House Report No. 97-760, 97th Congress, 2d Sess., and conversation with CBO official, September 1982.

Table VIII-3.—PUBLIC LAW 98-369, DEFICIT REDUCTION ACT OF 1984 (DEFRA) CONGRESSIONAL BUDGET OFFICE ESTIMATES OF CHANGES IN MEDICAID OUTLAYS MADE AT THE TIME OF ENACTMENT, FISCAL YEARS 1984-89

[In millions of dollars]

	Fiscal Year 1984	Fiscal Year 1985	Fiscal Year 1986	Fiscal Year 1987	Fiscal Year 1988	Fiscal Year 1989
Medicaid provisions:						
Clinical lab payments	−$10	−$49	−$57	−$67	−$60	−$69
Revaluation of assets	−2	−20	−40	−55	−80	−95
Pregnant women and children	0	40	90	140	195	260
Recertification of SNF and ICF care	−1	−6	0	1	1	1
Increased ceilings for territories	20	20	20	20	20	20
Payments for psychiatric hospital services	3	10	6	3	0	0
Assignment of rights to medical support	0	−7	−7	−8	−9	−10
Subtotal, Medicaid provisions	10	−12	12	34	67	107
Other items:						
Impact of Medicare provisions	0	−28	−6	27	42	45
Impact of AFDC provisions		145	195	205	235	245
Impact of SSI provisions		2	10	15	25	35
Other		0	−210	−240	−255	−275
Subtotal, other items		119	−11	7	47	50
Total	10	107	1	41	114	157

Source: U.S. Congressional Budget Office. Unpublished tables. August 1984.

Table VIII-4.—PUBLIC LAW 99-272, CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA), CONGRESSIONAL BUDGET OFFICE ESTIMATES OF CHANGES IN MEDICAID OUTLAYS MADE AT TIME OF ENACTMENT, FISCAL YEARS 1987-91

[In million of dollars]

	Fiscal Year 1987	Fiscal Year 1988	Fiscal Year 1989	Fiscal Year 1990	Fiscal Year 1991
Medicaid provisions:					
Services for pregnant women	$40	$40	$45	$45	$45
Third party liability	−25	−30	−30	−35	−40
Revaluation of assets	25	30	35	40	45
Coverage start date for institutionalized persons	5	5	5	5	5
Coverage of children	5	5	5	5	5
Overpayment recovery	5	5	5	5	5
Subtotal, Medicaid provisions	55	55	65	65	65
Impact of other provisions	4	4	4	4	4
Total	59	59	69	69	69

Source: Congressional Budget Office. Unpublished tables. April 1986.

Table VIII–5.—PUBLIC LAW 99–509, OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (OBRA86), CONGRESSIONAL BUDGET OFFICE ESTIMATE OF CHANGES IN MEDICAID OUTLAYS MADE AT THE TIME OF ENACTMENT, FISCAL YEARS 1987–91

[In millions of dollars]

	Fiscal Year 1987	Fiscal Year 1988	Fiscal Year 1989	Fiscal Year 1990	Fiscal Year 1991
Optional coverage of pregnant women and children	$25	$85	$110	$145	$185
Optional coverage of elderly and disabled	45	170	240	295	355
Respiratory care services	−2	0	0	0	0
Hold harmless for Medicaid matching percentages	50	0	0	0	0
Respite care pilot project	1	2	2	0	0
Presumptive eligibility	2	2	2	2	2
Total	121	259	354	442	542

Source: Congressional Budget Office. Unpublished tables. October 1986.

Table VIII–6.—PUBLIC LAW 100–203, OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (OBRA87), CONGRESSIONAL BUDGET OFFICE ESTIMATE OF CHANGES IN MEDICAID OUTLAYS MADE AT THE TIME OF ENACTMENT, FISCAL YEARS 1988–90

[In millions of dollars]

Provisions	1988	1989	1990
Coverage for pregnant women and children	$15	$90	$105
Nursing home requirements:			
Increase in nurse staff requirements	0	0	0
Nurse aide training	0	35	55
Social worker requirements	0	0	1
Increase in administrative, recordkeeping and personnel costs	0	5	10
Other requirements on institution	0	0	10
New survey and certification requirement	0	3	25
Increased match for survey and certification	0	0	15
Subtotal, nursing home requirements	0	43	116
Payment adjustment for territories	8	14	17
Clinic services for homeless	15	30	35
Payments to disproportionate share hospitals	5	30	60
Community-based services for disabled children: Technical amendment	1	2	2
Total	44	209	335

Source: Congressional Budget Office. Unpublished tables. December 1987.

Table VIII–7.—PUBLIC LAW 100–360, MEDICARE CATASTROPHIC COVERAGE ACT OF 1988, CONGRESSIONAL BUDGET OFFICE ESTIMATES OF CHANGES IN MEDICAID MADE AT THE TIME OF ENACTMENT, FISCAL YEARS 1989–93

[In millions of dollars]

	Fiscal Year 1989	Fiscal Year 1990	Fiscal Year 1991	Fiscal Year 1992	Fiscal Year 1993
Offsets from Medicare provisions	$45	−$247	−$398	−$495	−$605
Medicaid buyin for Medicare	106	231	435	591	665
Spousal protection	−6	58	339	210	229
Pregnant women/infants	5	50	125	160	195
OBRA87 technical amendments/other	−15	−4	0	8	11
Net Medicaid effect	45	388	501	474	495

Source: Congressional Budget Office. Unpublished tables. June 1988.

CHAPTER IX. MEDICAID BENEFICIARY AND PAYMENT INFORMATION, FISCAL YEAR 1986 [1]

INTRODUCTION

The Medicaid program is a joint Federal-State government program that provides medical assistance to certain low income and other specified groups of individuals. The program is separately administered by each State, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. Within limits established by the Federal Government, each State determines who is covered, what type of medical services are provided, as well as the level of reimbursement for the services. As a result, there is a substantial amount of variation in the number of people covered by the program and the types of services used in each State. This chapter provides State-by-State statistical detail on Medicaid beneficiaries and services for fiscal year 1986. The chapter is intended to provide State-by-State background data; it is a data supplement for the discussions in previous chapters (especially chapter II and chapter III). Program trend data, as well as national level statistics are provided and analyzed in Chapter I (Overview).

I. STATISTICAL INFORMATION ON THE MEDICAID PROGRAM

The statistical information presented in this chapter is based on information submitted by the States to the Health Care Financing Administration (HCFA) using HCFA form–2082, as reported by HCFA, September 25, 1987. Program statistics are summarized by each State from the Medicaid claims processed within the fiscal year. Data submitted on these forms include the number of beneficiaries and amount of vendor payments by eligibility status, whether the beneficiary received cash assistance payments, the type of services used, and certain other demographic characteristics.

Since individual States are responsible for administering their separate State programs there are some State to State differences in how beneficiaries or payments are counted between the States on the HCFA form. For example, the number of "Ribicoff children," children who except for the "dependency criteria" meet AFDC eligibility (see chapter II), can be located in one of two places on the form. Some States record these children in the "Categorically Needy, with no cash assistance payments" eligibility category of the form, other States place them in the "Other" eligibility criteria on the form.

In some instances, State administrative mechanisms were being changed during the fiscal year. One consequence of this type of change is that some States forms were not filed on time or contained missing data. In these instances, HCFA provides some State level estimates based on information contained from the previous year's form or by aggregating monthly claims data submitted by the States. However, HCFA did not provide estimates for every data element on the form.

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[1] Estimates in this chapter were prepared by Richard Rimkunas.

Despite these limitations, information contained on these forms provide the best description of the Medicaid program currently available.

II. ELIGIBILITY DATA

Tables IX–1 through IX–5 present State by State data on Medicaid beneficiaries. In fiscal year 1986, there were 22.5 million Medicaid beneficiaries nationwide. As noted in Chapter I, a handful of States dominate the number of beneficiaries in the program.

Approximately three-quarters of Medicaid beneficiaries also received cash assistance payments (table IX–1). The five States with the largest share of Medicaid beneficiaries receiving cash assistance are: California, New York, Michigan, Ohio, and Illinois. The Medically Needy eligibility category is an optional category not offered by all States. In fiscal year 1986, the Medically Needy represented about 16 percent of all beneficiaries. Beneficiaries in this eligibility category were dominated by two States and Puerto Rico. Twenty-three percent of the Medically Needy resided in California, fifteen percent in New York, and 23 percent in Puerto Rico.

Table IX–2 shows that, excluding the territories, 70 percent of beneficiaries were children or adults in families with dependent children. An additional 4 percent of beneficiaries are classified as "other." The majority of persons in this category are children not meeting the definition of "dependent children". For example, the child may be in a two-parent family where the principal breadwinner is not employed.

Tables IX–3 through IX–5 present per beneficiary vendor payment data by eligibility category. Excluding the territories, the average nationwide figures range from $521 for children in AFDC families that are receiving a cash payment to $12,470 for a blind medically needy beneficiary. These figures reflect both the use of more costly health services by adults versus children as well as the likelihood that a medically needy person frequently becomes eligible after incurring some medical expenses (thus signaling the potential need for additional health services). Among other items, the interstate variations in per capita costs by eligibility category reflect State variations in the amount, duration, and scope of covered services and the payment for such services.

III. SERVICE DATA

Tables IX–6 through IX–10 show Medicaid payments by type of service by State for fiscal year 1986. Five service categories account for almost 80 percent of total program spending. Spending on nursing home services (i.e., skilled nursing facilities, and intermediate care facilities) represent the largest service payment category nationwide; these two services represent 30 percent of nationwide Medicaid spending. Inpatient hospital services represent the next largest service category, 25 percent nationwide; followed by spending on intermediate care facilities for the mentally retarded, 12 percent; payments for prescription drugs, almost 7 percent; and physician services, 6 percent.

Table IX–1.—MEDICAID BENEFICIARIES BY MAINTENANCE ASSISTANCE STATUS, FISCAL YEAR 1986

State	Categorically needy		Medically needy	Unduplicated Total [1]
	Receiving AFDC or SSI payments	Not receiving AFDC or SSI payments		
Alabama	297,664	30,835	0	316,411
Alaska	24,863	3,857	0	28,720
Arkansas	154,580	23,393	25,369	203,342
California	2,508,240	111,700	846,160	3,466,100
Colorado	143,001	0	6,860	149,030
Connecticut	143,595	21,914	51,134	216,643
Delaware	34,643	6,581	0	39,270
District of Columbia	78,952	11,052	8,016	98,020
Florida	505,471	81,415	729	587,615
Georgia	430,861	85,748	4,108	483,514
Hawaii	76,206	202	19,141	88,901
Idaho	28,035	12,256	0	40,291
Illinois	862,449	46,487	154,605	1,063,541
Indiana	226,994	95,882	0	297,755
Iowa	181,329	52,425	9,298	221,905
Kansas	100,463	5,828	29,990	131,046
Kentucky	303,464	10,245	133,808	414,859
Louisiana	387,456	47,614	11,353	446,423
Maine	96,859	33,995	7,601	125,076
Maryland	258,916	4,352	60,136	323,404
Massachusetts	384,704	38,527	105,700	528,931
Michigan	994,011	79,299	202,941	1,119,724
Minnesota	232,640	23,231	89,720	344,459
Mississippi	208,659	110,212	0	318,871
Missouri	247,296	112,646	0	359,942
Montana	39,493	7,307	5,411	52,211
Nebraska	63,294	35,844	2,913	102,051
Nevada	28,095	6,074	0	32,545
New Hampshire	19,423	11,894	4,033	35,350
New Jersey	506,291	97,174	547	581,211
New Mexico	83,357	8,489	0	91,846
New York	1,679,374	91,314	551,940	2,322,628
North Carolina	268,267	36,882	73,069	378,218
North Dakota	24,331	349	15,470	40,150
Ohio	908,041	170,810	0	1,078,851
Oklahoma	183,390	36,297	22,652	242,339
Oregon	115,573	42,734	4,217	162,524
Pennsylvania	811,194	237,567	143,352	1,099,321
Rhode Island	74,177	11,362	11,664	97,203
South Carolina	228,142	90,536	46,239	262,136
South Dakota	27,323	9,328	0	36,651
Tennessee	297,977	71,139	25,557	394,673
Texas	721,648	143,033	14,304	878,985
Utah	54,256	14,446	11,681	75,622
Vermont	32,583	13,943	3,486	50,012
Virginia	250,044	25,321	38,825	314,190
Washington	259,168	103,699	25,074	357,879
West Virginia	179,512	28,003	3,659	211,174
Wisconsin	375,138	160,049	23,136	409,401

Table IX–1.—MEDICAID BENEFICIARIES BY MAINTENANCE ASSISTANCE STATUS, FISCAL YEAR 1986—Continued

State	Categorically needy		Medically needy	Unduplicated Total [1]
	Receiving AFDC or SSI payments	Not receiving AFDC or SSI payments		
Wyoming	18,013	2,996	0	21,009
Puerto Rico	431,340	476,469	854,043	1,761,833
Virgin Islands	5,076	317	8,464	13,857
U.S. total	16,159,455	2,506,286	2,793,898	20,741,973
All jurisdictions [2]	16,595,871	2,983,072	3,656,405	22,517,663

[1] In some instances the sum of individual State's eligibility categories do not equal the unduplicated totals. This occurs because a small number of beneficiaries may be counted in more than one eligibility category during the year.

[2] U.S. total includes information for 49 States (Arizona does not report information using the 2082), and the District of Columbia. All jursidiction total includes data from the States, D.C., Puerto Rico and the Virgin Islands, but excludes data from American Samoa, Guam, and the Northern Mariana Islands.

Note: Beneficiaries are individuals who receive any Medicaid covered services during the year.

Source: Table prepared by Congressional Research Service. Based on data contained in HCFA form 2082.

Table IX–2.—MEDICAID BENEFICIARIES BY ELIGIBILITY STATUS, FISCAL YEAR 1986

State	Aged	Blind	Disabled	Families with dependent children		Other [1]	Unduplicated Total [2]
				Children	Adults		
Alabama	82,221	1,718	71,966	116,029	56,142	3,539	316,411
Alaska	2,593	60	2,380	15,176	6,703	3,857	28,720
Arkansas	51,002	1,349	44,162	61,214	33,173	12,442	203,342
California	469,860	23,960	512,440	1,375,980	860,420	223,440	3,466,100
Colorado	30,189	192	20,900	68,286	31,250	6,860	149,030
Connecticut	35,563	193	23,730	94,288	49,519	13,350	216,643
Delaware	5,405	109	5,295	18,945	10,121	1,668	39,270
District of Columbia	9,729	59	14,815	45,365	24,279	3,773	98,020
Florida	115,023	2,913	113,173	236,711	111,949	7,846	587,615
Georgia	92,322	3,020	103,730	221,769	110,622	2,376	483,514
Hawaii	11,055	196	8,218	47,335	27,681	1,069	88,901
Idaho	6,087	40	6,532	18,436	8,530	666	40,291
Illinois	80,963	1,204	136,311	542,076	282,878	20,109	1,063,541
Indiana	44,154	1,074	43,889	144,763	76,947	12,049	297,755
Iowa	30,785	759	23,704	103,193	67,382	20,786	221,905
Kansas	45,787	225	17,477	69,060	35,266	5,697	131,046
Kentucky	54,127	2,048	72,255	191,145	115,361	12,581	414,859
Louisiana	92,164	1,812	69,698	193,940	88,278	531	446,423
Maine	20,833	265	19,951	61,838	36,546	0	125,076
Maryland	42,737	357	38,649	161,259	76,097	4,305	323,404
Massachusetts	103,427	7,571	76,779	188,496	115,584	37,074	528,931
Michigan	95,708	2,353	148,320	625,516	349,409	67,978	1,119,724
Minnesota	56,912	658	36,167	138,308	84,483	28,960	344,459
Mississippi	62,564	1,710	61,413	126,920	56,002	10,262	318,871
Missouri	64,036	1,294	54,050	152,861	84,978	2,723	359,942
Montana	6,658	95	7,467	21,733	15,009	1,249	52,211
Nebraska	15,627	183	10,727	42,449	25,146	7,919	102,051
Nevada	6,105	411	5,138	13,122	7,563	2,034	32,545
New Hampshire	8,393	295	5,384	9,864	11,402	12	35,350
New Jersey	66,124	1,175	75,830	295,179	149,895	15,809	581,211
New Mexico	12,253	461	17,854	41,104	17,932	2,242	91,846

Table IX-2.—MEDICAID BENEFICIARIES BY ELIGIBILITY STATUS, FISCAL YEAR 1986—Continued

State	Aged	Blind	Disabled	Families with dependent children		Other [1]	Unduplicated Total [2]
				Children	Adults		
New York	353,387	4,002	302,758	989,349	529,408	143,724	2,322,628
North Carolina	67,445	1,492	51,113	161,358	92,159	4,651	378,218
North Dakota	9,266	53	4,973	14,227	12,452	175	40,150
Ohio	94,679	1,631	112,564	574,811	295,088	78	1,078,851
Oklahoma	54,496	475	27,462	105,556	51,359	2,991	242,339
Oregon	18,214	958	18,585	75,216	44,295	5,256	162,524
Pennsylvania	123,664	1,546	139,751	602,751	269,994	70,958	1,099,321
Rhode Island	19,053	304	17,823	38,170	21,173	680	97,203
South Carolina	45,705	1,887	55,899	161,503	99,614	1,928	262,136
South Dakota	7,971	141	6,031	14,468	6,852	1,188	36,651
Tennessee	72,126	2,540	84,166	168,600	57,578	9,663	394,673
Texas	213,305	4,384	117,049	369,634	173,606	1,007	878,985
Utah	7,913	88	8,886	34,777	21,818	9,428	75,622
Vermont	7,454	90	7,273	21,384	12,831	980	50,012
Virginia	57,566	1,150	49,394	127,305	71,018	7,757	314,190
Washington	42,275	387	48,943	195,191	97,326	5,879	357,879
West Virginia	35,668	353	41,688	71,770	59,859	1,836	211,174
Wisconsin	85,243	1,323	78,182	252,606	154,765	10,064	409,401
Wyoming	2,877	57	1,560	8,316	8,161	38	21,009
Puerto Rico	0	919	76,622	593,648	537,070	553,593	1,761,833
Virgin Islands	1,152	3	571	7,673	3,622	836	13,857
U.S. total	3,138,713	80,620	3,022,504	9,429,352	5,105,903	811,487	20,741,973
All jurisdictions [3]	3,139,865	81,542	3,099,697	10,030,673	5,646,595	1,365,916	22,517,663

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[1] This category is composed predominantly of children not meeting the AFDC definition of "dependent" children (i.e., "Ribicoff" children). Children in two-parent families, children who live in privately subsidized foster care, or children who live in institutional settings like intermediate care facilities would be counted in this category.

[2] Unduplicated totals do not always equal the sum of eligibility categories. This occurs since a number of beneficiaries may become eligible for the program in more than one eligibility category during the year.

[3] U.S. total includes information for 49 States (Arizona does not report information using the 2082), and the District of Columbia. All jursidiction total includes data from the States, D.C., Puerto Rico and the Virgin Islands, but excludes data from American Samoa, Guam, and the Northern Mariana Islands.

Note: Beneficiaries are individuals who receive any Medicaid covered service in the fiscal year.
Source: Table prepared by Congressional Research Service. Based on data contained in HCFA form 2082.

Table IX-3.—MEDICAID PAYMENTS PER BENEFICIARY FOR CATEGORICALLY NEEDY BENEFICIARIES WHO RECEIVE SSI OR AFDC PAYMENTS, FISCAL YEAR 1986

State	All categorically needy beneficiaries receiving cash assistance	SSI aged	SSI blind	SSI disabled	AFDC children	AFDC adults
Alabama	$906	$992	$1,418	$1,813	$326	$755
Alaska	2,986	8,849	6,555	12,269	775	1,481
Arkansas	1,600	1,527	2,359	3,415	597	864
California	1,018	1,031	1,668	2,724	397	898
Colorado	2,017	3,749	13,040	5,879	399	724
Connecticut	970	1,727	3,564	3,260	590	1,130
Delaware	1,320	2,881	3,496	3,939	496	984
District of Columbia	1,412	5,330	2,015	4,670	368	702
Florida	1,188	1,584	1,855	2,865	360	805
Georgia	1,312	1,529	2,253	2,857	425	1,138

Table IX–3.—MEDICAID PAYMENTS PER BENEFICIARY FOR CATEGORICALLY NEEDY BENEFICIARIES WHO RECEIVE SSI OR AFDC PAYMENTS, FISCAL YEAR 1986—Continued

State	All categorically needy beneficiaries receiving cash assistance	SSI aged	SSI blind	SSI disabled	AFDC children	AFDC adults
Hawaii	924	2,009	3,361	3,467	406	930
Idaho	757	1,301	1,200	2,061	450	975
Illinois	1,163	2,818	3,848	4,858	466	941
Indiana	1,433	3,717	3,609	6,139	604	1,406
Iowa	1,134	1,880	1,825	4,216	478	926
Kansas	1,123	819	2,190	3,674	337	671
Kentucky	1,030	1,176	1,842	2,483	356	782
Louisiana	1,364	1,893	2,498	3,651	471	1,112
Maine	1,301	2,283	2,176	3,711	462	1,030
Maryland	1,251	2,455	2,238	3,427	656	1,175
Massachusetts	1,995	2,798	2,340	5,669	719	1,287
Michigan	1,073	2,143	2,78	3,771	473	1,126
Minnesota	1,709	5,134	7,087	9,776	443	1,075
Mississippi	816	1,373	1,657	1,815	303	718
Missouri	610	1,036	1,478	1,596	434	692
Montana	1,406	3,337	2,752	4,341	469	1,092
Nebraska	1,338	3,163	4,916	4,368	505	1,022
Nevada	1,745	1,446	3,124	5,450	635	1,306
New Hampshire	1,685	1,333	6,820	6,116	321	966
New Jersey	1,388	3,108	2,791	4,509	477	1,186
New Mexico	1,380	1,518	4,170	3,186	593	1,240
New York	2,168	6,390	11,693	6,501	670	1,316
North Carolina	1,239	2,072	3,077	3,849	468	922
North Dakota	2,057	4,292	2,728	6,941	542	1,211
Ohio	1,316	3,733	2,966	4,873	1,211	358
Oklahoma	854	1,806	1,608	2,523	276	440
Oregon	883	2,627	2,620	2,615	380	941
Pennsylvania	1,131	2,704	2,108	3,384	452	871
Rhode Island	1,240	3,030	3,077	3,670	379	807
South Carolina	1,039	1,196	1,480	2,330	337	811
South Dakota	1,885	2,768	3,033	5,520	556	1,053
Tennessee	1,405	1,329	2,106	2,631	673	1,293
Texas	1,410	1,876	2,704	4,006	423	1,105
Utah	1,283	3,133	2,731	5,697	430	974
Vermont	1,440	2,011	1,599	4,441	385	882
Virginia	1,290	2,298	2,325	3,436	370	882
Washington	1,137	6,399	6,273	16,359	491	929
West Virginia	654	988	1,491	1,073	370	556
Wisconsin	1,078	1,631	4,479	3,627	382	573
Wyoming	1,030	2,416	700	2,725	511	956
Puerto Rico	86	N/A	277	96	96	72
Virgin Islands	280	532	370	646	195	325
U.S. totals	1,300	2,253	2,641	3,764	521	952
All jurisdictions [1]	1,268	2,253	2,633	3,690	511	916

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[1] U.S. total includes payment information for 49 States (Arizona does not report information using the 2082), and the District of Columbia. All jursidiction total includes data from the States, D.C., Puerto Rico and the Virgin Islands, but excludes data from American Samoa, Guam, and the Northern Mariana Islands.

Note: Beneficiaries are individuals who receive any Medicaid covered services in the fiscal year.

Source: Table prepared by Congressional Research Service, Education and Public Welfare Division. Estimates based on data obtained from HCFA form 2082.

Table IX–4.—MEDICAID PAYMENTS PER BENEFICIARY FOR CATEGORICALLY NEEDY BENEFICIARIES NOT RECEIVING SSI OF AFDC PAYMENTS, FISCAL YEAR 1986

State	All categorically needy not receiving cash assistance	Aged	Blind	Disabled	Children	Adults	Other [1]
Alabama	$4,540	$6,319	$5,729	$13,708	$663	$1,147	$477
Alaska	2,829	N/A	N/A	N/A	N/A	N/A	2,829
Arkansas	6,295	5,818	16,044	17,899	556	1,113	3,868
California	455	1,124	409	1,001	256	557	N/A
Colorado	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Connecticut	7,335	10,897	8,035	11,144	756	1,123	2,592
Delaware	5,066	9,979	873	15,322	379	431	429
District of Columbia	5,183	13,131	N/A	9,598	352	576	936
Florida	4,948	8,914	12,745	16,240	282	331	978
Georgia	2,909	5,711	4,817	9,135	395	1,077	555
Hawaii	10,063	1,262	54	13,959	174	54	N/A
Idaho	5,242	6,134	4,651	7,064	1,021	743	1,095
Illinois	853	1,218	435	2,631	447	776	1,180
Indiana	5,248	7,744	4,479	7,873	683	1,041	1,303
Iowa	3,123	4,987	5,064	15,841	361	474	1,136
Kansas	1,088	576	487	3,678	1,181	438	218
Kentucky	197	722	1,466	1,424	123	185	N/A
Louisiana	4,813	6,232	9,306	12,761	870	681	665
Maine	4,248	9,302	1,625	9,066	501	838	N/A
Maryland	10,206	17,328	28,530	30,338	461	700	N/A
Massachusetts	1,663	2,020	14,204	3,141	458	704	1,304
Michigan	994	2,670	1,645	2,106	289	458	N/A
Minnesota	11,130	11,275	15,404	20,746	336	639	740
Mississippi	1,328	2,645	1,005	1,609	296	676	381
Missouri	3,595	4,920	8,298	3,638	499	494	690
Montana	4,054	9,294	5,139	11,296	664	934	966
Nebraska	2,682	5,740	2,849	8,659	396	672	1,275
Nevada	4,972	8,711	7,931	14,594	125	207	1,027
New Hampshire	6,739	11,306	12,640	14,779	924	638	N/A
New Jersey	5,956	10,980	8,935	16,976	576	1,425	3,250
New Mexico	5,858	8,998	21,631	18,292	1,298	1,613	1,722
New York	971	8,336	7,183	2,440	1,192	1,310	961
North Carolina	2,492	8,339	7,523	8,567	773	1,056	5,345
North Dakota	4,407	5,546	2,474	5,261	1,804	546	1,360
Ohio	5,005	7,440	5,753	8,006	826	N/A	1,113
Oklahoma	5,367	5,630	5,853	12,121	2,798	2,843	2,748
Oregon	3,639	5,529	19,175	8,297	336	1,076	761
Pennsylvania	3,479	8,411	6,522	10,638	1,029	382	537
Rhode Island	10,710	10,823	9,354	15,862	812	1,103	680
South Carolina	1,528	7,331	7,680	13,841	135	221	836
South Dakota	5,515	7,360	10,827	15,948	763	754	929
Tennessee	3,750	7,030	1,363	10,794	596	945	2,787
Texas	4,135	6,031	8,271	15,411	604	1,387	635
Utah	3,707	5,807	7,916	8,730	660	1,274	N/A
Vermont	2,066	7,666	3,230	9,408	442	852	1,075
Virginia	3,721	12,881	2,596	22,171	462	1,171	1,075
Washington	2,899	5,315	2,470	2,834	345	501	903
West Virginia	2,778	4,743	8,193	3,877	657	1,088	640
Wisconsin	3,098	7,098	4,931	8,396	243	207	786
Wyoming	4,766	9,121	10,084	8,137	384	324	976
Puerto Rico	73	N/A	192	84	78	63	82

Table IX-4.—MEDICAID PAYMENTS PER BENEFICIARY FOR CATEGORICALLY NEEDY BENEFICIARIES NOT RECEIVING SSI OF AFDC PAYMENTS, FISCAL YEAR 1986—Continued

State	All categorically needy not receiving cash assistance	Aged	Blind	Disabled	Children	Adults	Other [1]
Virgin Islands	156	N/A	N/A	N/A	186	56	N/A
U.S. total	3,478	6,859	7,652	7,727	566	711	1,176
All jurisdictions [2]	2,934	6,859	7,361	7,484	450	499	1,043

[1] This category is composed predominantly of children not meeting the AFDC definition of "dependent children," (i.e., "Ribicoff children"). Children in this category would include children in two-parent families, children who live in privately subsidized foster care, and children in institutional settings like intermediate care facilities.

[2] U.S. total includes payment information for 49 States (Arizona does not report information using the 2082), and the District of Columbia. All jursidiction total includes data from the States, D.C., Puerto Rico and the Virgin Islands, but excludes data from American Samoa, Guam, and the Northern Mariana Islands.

Note: Entries with N/A indicate data not available or no beneficiaries in eligibility category.

Note: Beneficiaries are individuals who receive any Medicaid covered services in the fiscal year.

Source: Table prepared by Congressional Research Service, Education and Public Welfare Division. Estimates based on data obtained from HCFA form 2082.

Table IX-5.—MEDICAID PAYMENTS PER BENEFICIARY FOR MEDICALLY NEEDY BENEFICIARIES, FISCAL YEAR 1986

State	All Medically Needy	Aged	Blind	Disabled	Children	Adults	Other [1]
Alabama	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Alaska	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Arkansas	$1,553	$451	$311	$2,630	$923	$1,168	$2,128
California	2,129	4,718	4,283	7,309	639	1,171	958
Colorado	1,728	N/A	N/A	N/A	N/A	N/A	1,728
Connecticut	7,339	10,895	8,110	11,144	773	1,138	2,593
Delaware	N/A	N/A	N/A	N/A	N/A	N/A	N/A
District of Columbia	4,059	10,674	14,781	6,713	381	610	303
Florida	183	109	22	604	111	193	65
Georgia	827	N/A	N/A	N/A	594	1,660	321
Hawaii	3,356	8,552	2,280	4,936	492	804	569
Idaho	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Illinois	4,089	5,204	7,604	7,437	593	953	480
Indiana	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Iowa	537	330	547	656	401	799	582
Kansas	3,981	4,343	4,632	6,388	432	585	3,207
Kentucky	1,660	6,589	5,825	8,150	353	785	1,374
Louisiana	1,946	685	1,340	4,231	857	1,275	N/A
Maine	1,617	2,467	8	3,337	704	1,379	N/A
Maryland	5,185	8,046	4,385	12,415	1,305	1,393	1,223
Massachusetts	7,884	10961	26,549	22,509	727	1,337	1,380
Michigan	3,069	5,783	4,910	7,028	450	919	1,020
Minnesota	4,329	7,462	6,362	9,093	651	1,177	1,208
Mississippi	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Missouri	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Montana	4,960	6,602	16,361	8,413	1,082	1,612	843
Nebraska	2,301	1,974	5,412	4,653	720	1,829	2,473
Nevada	N/A	N/A	N/A	N/A	N/A	N/A	N/A
New Hampshire	5,008	7,192	733	6,260	407	1,063	567
New Jersey	116	80	263	68	56	591	N/A

Table IX–5.—MEDICAID PAYMENTS PER BENEFICIARY FOR MEDICALLY NEEDY BENEFICIARIES, FISCAL YEAR 1986—Continued

State	All Medically Needy	Aged	Blind	Disabled	Children	Adults	Other [1]
New Mexico	N/A	N/A	N/A	N/A	N/A	N/A	N/A
New York	8,142	15508	32,540	14,636	847	1,167	915
North Carolina	4,468	5,617	5,945	7,980	1,223	1,468	9,385
North Dakota	4,529	7,276	3,230	9,566	694	1,119	11,622
Ohio	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Oklahoma	3,132	4,238	868	6,093	1,896	2,939	2,651
Oregon	683	N/A	N/A	N/A	594	850	N/A
Pennsylvania	1,733	7,264	5,960	9,898	752	703	781
Rhode Island	4,202	4,990	2,233	4,428	733	651	316
South Carolina	400	N/A	N/A	N/A	356	443	N/A
South Dakota	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tennessee	1,134	N/A	N/A	N/A	1,061	1,603	N/A
Texas	1,340	N/A	N/A	N/A	1,219	1,612	265
Utah	1,467	1,503	2,241	2,621	2,038	2,034	1,335
Vermont	5,407	6,765	4,981	6,737	1,033	1,814	117
Virginia	4,581	7,019	5,934	5,387	481	1,116	1,385
Washington	1,198	1,031	1,946	2,231	628	1,197	1,089
West Virginia	1,535	2,560	125	1,953	642	1,206	N/A
Wisconsin	845	1,189	1,272	1,686	297	399	323
Wyoming	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Puerto Rico	98	N/A	89	104	87	72	111
Virgin Islands	309	405	466	860	232	412	212
U.S. totals	3,990	8,646	12470	9,755	707	1,087	1,126
All jurisdictions [2]	3,073	8,636	11067	9,276	591	849	603

[1] This category is composed of children not meeting the AFDC definition of "dependent children," (i.e., "Ribicoff children"). Some types of children included in this category would be children living in two-parent families, children living in privately subsidized foster care, or children living in institutions like intermediate care facilities.

[2] U.S. total includes payment information for all States with medically needy programs, and the District of Columbia. All jursidiction total includes data from the States, D.C., Puerto Rico and the Virgin Islands, but excludes data from American Samoa, Guam, and the Northern Mariana Islands.

Note: Entries with N/A indicate data is not available or no recipients in eligibility category. See chapter II for a listing of States offering medically needy programs. Beneficiaries are individuals who receive any Medicaid covered service in the fiscal year.

Source: Table prepared by Congressional Research Service, Education and Public Welfare Division. Estimates based on data obtained from HCFA form 2082.

Table IX–6.—MEDICAID PAYMENTS BY TYPE OF HOSPITAL SERVICE, BY STATE, FISCAL YEAR 1986

[In thousands of dollars]

State	All services total	Inpatient hospital services	Impatient mental health	Outpatient hospital
Alabama	$409,630	$80,158	$2,475	$13,006
Alaska	85,144	23,434	233	7,175
Arkansas	433,914	96,713	13,770	6,401
California	4,405,204	1,478,305	12,732	228,079
Colorado	300,213	31,579	7,862	15,890
Connecticut	675,300	123,634	28,183	36,287
Delaware	79,074	17,321	2,094	5,404
District of Columbia	201,278	1,872	16,130	17,357
Florida	1,003,334	262,311	7,983	32,097
Georgia	818,132	220,542	0	48,711
Hawaii	136,678	30,560	0	5,756
Idaho	85,476	15,624	0	3,445

Table IX–6.—MEDICAID PAYMENTS BY TYPE OF HOSPITAL SERVICE, BY STATE, FISCAL YEAR 1986—Continued

[In thousands of dollars]

State	All services total	Inpatient hospital services	Impatient mental health	Outpatient hospital
Illinois	1,674,983	558,080	11,328	57,195
Indiana	828,360	181,046	5,591	37,380
Iowa	374,395	74,749	3,285	16,330
Kansas	238,508	36,550	10,344	6,744
Kentucky	536,595	140,350	10,559	27,729
Louisiana	779,586	167,518	12,721	26,532
Maine	282,772	75,831	0	17,495
Maryland	680,033	206,004	21,757	46,939
Massachusetts	1,664,819	506,027	6,490	122,495
Michigan	1,767,799	591,812	53,035	100,896
Minnesota	1,044,425	126,609	13,095	24,793
Mississippi	316,609	75,210	0	17,328
Missouri	555,792	115,465	6,864	30,813
Montana	111,987	25,534	0	3,819
Nebraska	187,544	40,756	2,923	5,564
Nevada	79,231	20,918	137	3,081
New Hampshire	133,085	15,558	4,688	3,389
New Jersey	1,281,420	316,974	60,155	74,850
New Mexico	164,773	48,095	0	8,765
New York	8,223,284	2,019,534	542,816	372,499
North Carolina	750,782	193,523	18,582	22,424
North Dakota	121,650	19,085	3,353	2,443
Ohio	2,049,528	572,571	13,269	131,884
Oklahoma	422,325	109,796	18,469	5,137
Oregon	260,402	34,497	5,930	10,699
Pennsylvania	1,992,768	422,020	100,428	52,217
Rhode Island	262,696	79,941	1,030	10,699
South Carolina	393,810	107,914	9,131	15,815
South Dakota	102,940	21,405	2,611	2,749
Tennessee	714,351	182,520	23,303	39,315
Texas	1,628,393	342,500	35	54,607
Utah	140,284	38,559	5,111	4,132
Vermont	94,567	16,768	690	3,736
Virginia	594,598	122,312	27,730	32,432
Washington	625,447	128,897	9,647	25,427
West Virginia	200,825	73,406	253	4,414
Wisconsin	919,695	112,194	14,087	37,295
Wyoming	32,835	9,854	252	1,426
Puerto Rico	155,928	55,796	0	100,133
Virgin Islands	4,081	1,577	0	1,647
U.S. totals	40,867,273	10,312,438	1,111,163	1,881,095
All jursidictions [1]	41,027,283	10,369,811	1,111,163	1,982,875

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[1] U.S. totals includes payment information for 49 States (Arizona does not report information using the 2082), and the District of Columbia. All jurisdiction total includes data from the States, D.C., Puerto Rico and Virgin Islands, but excludes data from American Samoa, Guam, and the Northern Mariana Islands.

Note: All services total includes Medicaid vendor payments for services other than hospital services.
Source: Table prepared by Congressional Research Service. Based on data contained in HCFA Form 2082.

Table IX–7.—MEDICAID PAYMENTS BY TYPE OF CLINIC SERVICE, BY STATE, FISCAL YEAR 1986

[In thousands of dollars]

State	All services total	Clinic service	Home health services	Rural health clinics	EPSDT	Family planning services
Alabama	$409,630	$3,502	$29,409	$98	$1,012	3,492
Alaska	85,144	2,843	63	107	913	321
Arkansas	433,914	9,866	5,369	0	346	596
California	4,405,204	129,562	7,238	1,520	33,497	24,765
Colorado	300,213	10,190	3,499	68	1,341	1,318
Connecticut	675,300	5,373	12,234	3	258	1,933
Delaware	79,074	44	2,741	0	50	1,058
District of Columbia	201,278	15,420	9,715	0	888	394
Florida	1,003,334	13,699	21,949	709	1,732	1,116
Georgia	818,132	13,779	19,550	297	2,853	8,642
Hawaii	136,678	553	455	0	85	947
Idaho	85,476	923	1,742	48	204	260
Illinois	1,674,983	17,878	3,121	0	4,476	11,843
Indiana	828,360	6,953	4,301	0	448	5,390
Iowa	374,395	1,558	3,633	103	343	4,203
Kansas	238,508	3,953	1,710	0	533	1,641
Kentucky	536,595	20,847	26,679	677	342	4,152
Louisiana	779,586	10,232	4,548	0	2,399	5,707
Maine	282,772	3,673	13,756	729	55	1,493
Maryland	680,033	7,053	13,334	92	1,785	6,773
Massachusetts	1,664,819	48,431	56,099	0	3,930	5,712
Michigan	1,767,799	2,005	7,932	0	5,001	23,672
Minnesota	1,044,425	852	25,876	0	1,408	3,137
Mississippi	316,609	0	2,405	212	2,754	2,649
Missouri	555,792	19,284	5,666	0	766	3,508
Montana	111,987	1,858	334	0	1,108	860
Nebraska	187,544	315	2,102	0	679	663
Nevada	79,231	90	2,671	7	282	513
New Hampshire	133,085	3,272	3,864	54	55	425
New Jersey	1,281,420	54,634	26,251	0	938	6,829
New Mexico	164,773	713	2,559	280	260	1,398
New York	8,223,284	202,341	66,350	0	6,618	27,035
North Carolina	750,782	9,395	20,076	1,073	2,226	4,793
North Dakota	121,650	1,357	6,036	0	167	357
Ohio	2,049,528	30,427	2,594	973	4,605	10,810
Oklahoma	422,325	1,203	84	0	411	519
Oregon	260,402	7,552	10,337	30	1,030	2,320
Pennsylvania	1,992,768	57,121	5,470	910	4,208	11,784
Rhode Island	262,696	0	7,283	69	321	590
South Carolina	393,810	5,480	8,475	1	1,768	2,595
South Dakota	102,940	673	6,430	146	62	245
Tennessee	714,351	26,860	7,308	83	2,670	5,681
Texas	628,393	0	90,403	0	2,632	10,092
Utah	140,284	662	548	35	31	695
Vermont	94,567	11,003	1,894	111	15	418
Virginia	594,598	7,389	16,324	0	1,363	2,309
Washington	625,447	16,025	6,151	95	1,664	3,276
West Virginia	200,825	1,037	1,174	1,542	1,193	815
Wisconsin	919,695	22,131	24,134	25	613	5,598
Wyoming	32,835	0	231	0	64	212

Table IX–7.—MEDICAID PAYMENTS BY TYPE OF CLINIC SERVICE, BY STATE, FISCAL YEAR 1986—Continued

[In thousands of dollars]

State	All services total	Clinic service	Home health services	Rural health clinics	EPSDT	Family planning services
Puerto Rico	155,928	0	0	0	0	0
Virgin Islands	4,081	0	0	0	23	39
U.S. totals	40,867,273	810,014	1,352,106	10,101	102,402	225,554
All jurisdictions [1]	41,027,283	810,014	1,352,106	10,101	102,425	225,593

[1] U.S. totals includes payment information for 49 States (Arizona does not report information using the 2082), and the District of Columbia. All jursidiction total includes data from the States, D.C., Puerto Rico and Virgin Islands, but excludes data from American Samoa, Guam, and the Northern Mariana Islands.

Note: All services total includes payments for services other than clinic services.
Source: Table prepared by Congressional Research Service. Based on data contained in HCFA Form 2082.

Table IX–8.—MEDICAID PAYMENTS BY TYPE OF LONG-TERM CARE SERVICE, BY STATE, FISCAL YEAR 1986

[In thousands of dollars]

State	All services total	Skilled nursing facilities	Intermediate care facilities	Intermediate care facilities for the mentally retarded
Alabama	$409,630	$11,092	$123,108	$49,391
Alaska	85,144	2,407	19,015	10,108
Arkansas	433,914	83,270	44,985	70,709
California	4,405,204	994,778	28,264	310,744
Colorado	300,213	149,283	0	0
Connecticut	675,300	37,379	270,651	79,689
Delaware	79,074	2,635	26,295	10,801
District of Columbia	201,278	4,747	66,270	31,312
Florida	1,003,334	60,583	303,757	122,983
Georgia	818,132	72,147	149,143	70,488
Hawaii	136,678	19,310	36,856	5,582
Idaho	85,476	9,801	23,287	16,991
Illinois	1,674,983	114,616	375,606	172,251
Indiana	828,360	86,755	268,534	42,611
Iowa	374,395	2,866	102,394	73,020
Kansas	238,508	1,789	81,060	46,543
Kentucky	536,595	34,834	118,263	38,458
Louisiana	779,586	4,928	203,415	142,789
Maine	282,772	3,700	96,619	26,402
Maryland	680,033	7,783	197,232	67,693
Massachusetts	1,664,819	210,834	262,967	241,938
Michigan	1,767,799	98,843	286,184	169,299
Minnesota	1,044,425	316,791	128,164	225,357
Mississippi	316,609	47,966	55,741	25,409
Missouri	555,792	8,803	219,461	45,205
Montana	111,987	1,222	43,123	9,343
Nebraska	187,544	11,246	56,999	24,473
Nevada	79,231	2,332	23,104	8,907
New Hampshire	133,085	758	66,578	11,537
New Jersey	1,281,420	37,926	335,463	179,462
New Mexico	164,773	1,604	41,833	19,880

Table IX-8.—MEDICAID PAYMENTS BY TYPE OF LONG-TERM CARE SERVICE, BY STATE, FISCAL YEAR 1986—Continued

[In thousands of dollars]

State	All services total	Skilled nursing facilities	Intermediate care facilities	Intermediate care facilities for the mentally retarded
New York	8,223,284	1,905,381	329,611	1,033,285
North Carolina	750,782	117,073	104,138	123,832
North Dakota	121,650	29,369	21,355	19,200
Ohio	2,049,528	394,509	259,633	253,821
Oklahoma	422,325	1,222	135,569	64,227
Oregon	260,402	4,855	72,943	52,065
Pennsylvania	1,992,768	111,341	565,569	347,286
Rhode Island	262,696	4,075	91,216	42,983
South Carolina	393,810	49,149	55,087	63,064
South Dakota	102,940	1,575	36,956	17,019
Tennessee	714,351	25,402	172,413	73,826
Texas	1,628,393	37,121	423,414	326,119
Utah	140,284	2,925	32,067	24,717
Vermont	94,567	1,012	30,379	13,331
Virginia	594,598	13,222	164,322	96,733
Washington	625,447	183,601	8,669	102,492
West Virginia	200,825	28,712	40,652	3,063
Wisconsin	919,695	300,140	167,564	74,928
Wyoming	32,835	1,955	14,327	0
Puerto Rico	155,928	0	0	0
Virgin Islands	4,081	0	0	0
U.S. totals	40,867,273	5,655,667	6,780,258	5,081,366
All jurisdictions [1]	41,027,283	5,655,667	6,780,258	5,081,366

[1] U.S. totals includes payment information for 49 States (Arizona does not report information using the 2082), and the District of Columbia. All jursidiction total includes data from the States, D.C., Puerto Rico and Virgin Islands, but excludes data from American Samoa, Guam, and the Northern Mariana Islands.

Note: All services total includes payments for services other than long-term care services.
Source: Table prepared by Congressional Research Service. Based on data contained in HCFA Form 2082.

Table IX-9.—MEDICAID PAYMENTS BY TYPE OF ANCILLARY SERVICE, BY STATE, FISCAL YEAR 1986

[In thousands of dollars]

State	All services total	Lab and x-ray services	Prescribed drugs	Other care
Alabama	$409,630	$6,859	$40,788	$2,154
Alaska	85,144	111	0	2,928
Arkansas	433,914	3,258	47,868	13,387
California	4,405,204	91,536	338,750	140,989
Colorado	300,213	857	18,728	35,937
Connecticut	675,300	1,227	33,109	14,926
Delaware	79,074	171	4,029	251
District of Columbia	201,278	1,100	10,226	4,543
Florida	1,003,334	8,476	101,191	19,307
Georgia	818,132	1,227	94,016	20,523
Hawaii	136,678	1,728	8,850	1,751
Idaho	85,476	989	2,133	1,829
Illinois	1,674,983	23,010	128,314	23,709
Indiana	828,360	1,209	65,817	34,011

Table IX-9.—MEDICAID PAYMENTS BY TYPE OF ANCILLARY SERVICE, BY STATE, FISCAL YEAR 1986—Continued

[In thousands of dollars]

State	All services total	Lab and x-ray services	Prescribed drugs	Other care
Iowa	374,395	647	28,157	5,368
Kansas	238,508	1,569	17,108	5,625
Kentucky	536,595	710	34,012	3,011
Louisiana	779,586	35,321	79,477	20,329
Maine	282,772	217	18,454	4,744
Maryland	680,033	2,619	40,790	13,916
Massachusetts	1,664,819	2,702	75,843	40,868
Michigan	1,767,799	17,570	115,145	94,786
Minnesota	1,044,425	669	46,452	49,401
Mississippi	316,609	1,229	41,352	1,908
Missouri	555,792	2,241	40,106	5,379
Montana	111,987	256	6,615	4,618
Nebraska	187,544	2,009	15,744	2,289
Nevada	79,231	363	4,216	2,552
New Hampshire	133,085	158	6,502	1,970
New Jersey	1,281,420	6,055	88,950	19,156
New Mexico	164,773	648	13,150	4,670
New York	8,223,284	66,375	368,326	209,160
North Carolina	750,782	12,269	55,989	1,142
North Dakota	121,650	330	6,490	2,318
Ohio	2,049,528	25,061	127,634	64,230
Oklahoma	422,325	105	12,987	36,115
Oregon	260,402	6,394	19,011	12,308
Pennsylvania	1,992,768	15,098	135,410	56,573
Rhode Island	262,696	368	13,443	2,876
South Carolina	393,810	667	29,979	7,124
South Dakota	102,940	1,184	4,534	1,163
Tennessee	714,351	12,930	68,865	5,813
Texas	1,628,393	38,217	110,129	13,686
Utah	140,284	240	8,384	1,827
Vermont	94,567	83	6,842	443
Virginia	594,598	4,081	50,135	9,451
Washington	625,447	9,170	35,870	28,991
West Virginia	200,825	1,260	15,918	3,878
Wisconsin	919,695	13,661	55,595	43,931
Wyoming	32,835	134	0	1
Puerto Rico	155,928	0	0	0
Virgin Islands	4,081	26	441	128
U.S. totals	40,867,273	424,368	2,691,433	1,097,861
All jurisdictions [1]	41,027,283	424,394	2,691,874	1,097,990

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[1] U.S. totals includes payment information for 49 States (Arizona does not report information using the 2082), and the District of Columbia. All jursidiction total includes data from the States, D.C., Puerto Rico and Virgin Islands, but excludes data from American Samoa, Guam, and the Northern Mariana Islands.

Note: All services total includes payments for services other than ancillary services.
Source: Table prepared by Congressional Research Service. Based on data contained in HCFA Form 2082.

Table IX–10.—MEDICAID PAYMENTS BY TYPE OF PRACTITIONER SERVICE, BY STATE, FISCAL YEAR 1986

[In thousands of dollars]

State	All services total	Physician services	Dental services	Other practitioner services
Alabama	$409,630	$37,763	$3,645	$1,677
Alaska	85,144	12,621	1,990	873
Arkansas	433,914	31,608	4,083	1,683
California	4,405,204	449,278	84,913	50,254
Colorado	300,213	21,749	1,427	485
Connecticut	675,300	22,781	4,198	3,433
Delaware	79,074	5,579	391	209
District of Columbia	201,278	19,867	1,011	427
Florida	1,003,334	34,640	8,075	2,728
Georgia	818,132	81,116	11,699	3,398
Hawaii	136,678	17,463	5,663	1,120
Idaho	85,476	6,767	710	724
Illinois	1,674,983	119,076	4,263	10,217
Indiana	828,360	68,693	13,572	6,048
Iowa	374,395	40,182	13,767	3,791
Kansas	238,508	17,774	4,273	1,292
Kentucky	536,595	65,791	7,452	2,731
Louisiana	779,586	54,010	8,631	1,030
Maine	282,772	15,241	1,879	2,484
Maryland	680,033	41,417	4,161	685
Massachusetts	1,664,819	52,188	18,883	9,412
Michigan	1,767,799	162,180	29,658	9,781
Minnesota	1,044,425	57,117	15,364	9,338
Mississippi	316,609	34,769	6,602	1,076
Missouri	555,792	39,920	9,079	3,232
Montana	111,987	8,736	2,511	2,051
Nebraska	187,544	16,692	3,070	2,020
Nevada	79,231	8,242	1,446	371
New Hampshire	133,085	3,567	428	284
New Jersey	1,281,420	46,127	20,692	6,958
New Mexico	164,773	16,976	2,751	1,190
New York	8,223,284	220,524	97,312	56,117
North Carolina	750,782	48,789	12,691	2,766
North Dakota	121,650	6,522	2,518	751
Ohio	2,049,528	115,033	28,165	14,308
Oklahoma	422,325	32,900	2,848	730
Oregon	260,402	17,035	2,495	899
Pennsylvania	1,992,768	75,361	26,304	5,667
Rhode Island	262,696	5,448	1,815	541
South Carolina	393,810	32,616	4,169	775
South Dakota	102,940	5,142	840	203
Tennessee	714,351	58,860	7,329	1,171
Texas	1,628,393	152,598	14,389	12,451
Utah	140,284	16,358	2,858	1,136
Vermont	94,567	6,656	785	401
Virginia	594,598	41,216	4,361	1,218
Washington	625,447	48,803	11,292	5,376
West Virginia	200,825	16,595	4,932	1,980
Wisconsin	919,695	34,452	9,447	3,898
Wyoming	32,835	3,286	896	197

Table IX-10.—MEDICAID PAYMENTS BY TYPE OF PRACTITIONER SERVICE, BY STATE, FISCAL YEAR 1986—Continued

[In thousands of dollars]

State	All services total	Physician services	Dental services	Other practitioner services
Puerto Rico	155,928	0	0	0
Virgin Islands	4,081	83	116	0
U.S. totals	40,867,273	2,548,125	531,735	251,587
All jursidictions [1]	41,027,283	2,548,208	531,852	251,587

[1] U.S. totals includes payment information for 49 States (Arizona does not report information using the 2082), and the District of Columbia. All jursidiction total includes data from the States, D.C., Puerto Rico and Virgin Islands, but excludes data from American Samoa, Guam, and the Northern Mariana Islands.

Note: All services total includes spending for services other than practitioner services.
Source: Table prepared by Congressional Research Service. Based on data contained in HCFA Form 2082.

CHAPTER X. REPORTS TO CONGRESS AND SELECTED BIBLIOGRAPHY [1]

I. REPORTS AND STUDIES REQUIRED BY LEGISLATION

Reports and studies required from the Secretary of Health and Human Services which are past due or due in the future:

Topic	Due date
NURSING FACILITIES	
Secretary of HHS shall report annually on the extent to which, under Medicaid, nursing facilities are complying with the requirements of subsections relating to provision of services, residents' rights, and administration and other matters. (section 4215 of Public Law 100–203, OBRA87)	annually
NEW YORK MATERNITY CARE DEMONSTRATION	
Secretary of HHS shall report to the Congress an evaluation of a demonstration project conducted by the State of New York (upon approval of application) of the project. for the purpose of testing its Prenatal/Maternity/Newborn Care Pilot Program as an alternative to existing Federal program. (section 4115(b) of Public Law 100–203, OBRA87)	Not later than 1 year after completion of the project
NEW JERSEY RESPITE CARE DEMONSTRATION	
Secretary of HHS shall enter into an agreement with the State of New Jersey to conduct a pilot project under Medicaid to determine the extent to which (1) the provision of respite care services to individuals at risk of institutionalization will delay or avert the need for institutional care, and (2) respite care services enhance and sustain the role of the family in providing long-term care services for the elderly and disabled individuals at risk of institutionalization. The State of New Jersey shall arrange for an independent evaluation of the Respite Care Project and transmit the evaluation to the Secretary. (section 9414(f) of Public Law 99–509, OBRA86)	Not more than 6 months after the conclusion of the project
HOME AND COMMUNITY-BASED SERVICES	
Secretary of HHS shall report to the Congress with respect to the results of studies currently evaluating home and community based health services, and make recommendations to improve the provision of such services. (section 339(b) of Public Law 97–414, the Orphan Drug Act)	January 1, 1985
SOCIAL HEALTH MAINTENANCE ORGANIZATIONS	
Secretary of HHS shall submit a final report to the Congress on projects regarding the approval of certain waivers for projects demonstrating the concept of social health maintenance organizations. (section 2355 of Public Law 98–369, DEFRA)	January 18, 1988

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[1] Prepared by Keith Hurt with the assistance of Shivaun Nurre.

Topic	Due date
MANDATORY SURGICAL SECOND OPINION	
Secretary of HHS shall report to Congress on State utilization review systems identifying those procedures which are high volume or high cost procedures among patients who are covered under the State Medicaid plan. Report should also include a list of those surgical procedures which require a mandatory second opinion. (section 9432(b) of Public Law 99–509, OBRA86)	October 1, 1988
ICF/MR REDUCTION PLANS	
Secretary of HHS shall submit to Congress a study on the implementation and results of permitting intermediate care facilities for the mentally retarded to submit correction and reduction plans. (section 9516 of Public Law 99–272, COBRA)	October 7, 1988
MMIS WAIVERS	
Secretary of HHS shall report to the Congress regarding waivers of percentum reductions to States not meeting requirements for mechanized claims processing and information retrieval systems (Good Cause Waivers). This report identifies any waivers granted to State whereby a percentum reduction would not apply and describes the basis for each determination. (section 1903(r)(8)(B) of Public Law 74–271, the Social Security Act)	no certain deadline
HOME HEALTH PROSPECTIVE PAYMENT DEMONSTRATION	
Secretary of HHS shall submit to Congress an interim report on the home health prospective payment demonstration project which shall develop and test alternative methods of paying home health agencies on a prospective basis for services furnished under the Medicare and Medicaid programs. (section 4027(c) of Public Law 100–203, OBRA87)	December 22, 1988
PROVIDER SANCTIONS	
Secretary of HHS shall report to Congress on the improved procedures for imposing sanctions against a person or practitioner under section 1156 of the Social Security Act which governs obligations, sanctions, penalties, hearings and review of health care practitioners and providers of health care services. (section 4095(e) of Public Law 100–203, OBRA87)	December 22, 1988
RECOVERY OF ICF/SNF SERVICES COSTS FROM BENEFICIARIES' ESTATES	
Secretary of HHS shall report to Congress on means of recovering amounts from the estates of deceased Medicaid beneficiaries (or estates of their spouses) to pay for ICF or SNF services furnished under Medicaid (section 411(k)(11) of Public Law 100–360, Medicare Catastrophic Coverage Act of 1988)	December 31, 1988
PRIVATE LONG-TERM CARE INSURANCE	
Secretary of HHS shall transmit to the Committee on Energy and Commerce of the House and to the Committee on Labor and Human Resources of the Senate the first of two reports concerning actions taken by the States to implement the recommendations developed by the Task Force on Long-Term Health Care Policies and to recommend additional action. (section 9601 of Public Law 99–272, COBRA)	March 7, 1989
INCENTIVE ARRANGEMENTS FOR HMO's AND COMPETITIVE PLANS	
Secretary of HHS shall report to Congress concerning incentive arrangements offered by HMO's and competitive medical plans, reviewing incentive arrangements in common use, evaluating their potential to pressure physicians to reduce or limit services in a medically inappropriate manner, and making recommendations. (section 9313(b)(3) of Public Law 99–509, OBRA86)	April 1, 1989

Topic	Due date
QUALITY OF CARE	
Secretary of HHS shall report to Congress the results of a study of the utilization of selected medical treatments and surgical procedures by Medicaid beneficiaries to assess the appropriateness, necessity and effectiveness of such treatments and procedures. (section 9432(a) of Public Law 99–509, OBRA86)	January 1, 1990
PRIVATE LONG-TERM CARE INSURANCE	
Secretary of HHS shall transmit to the Committee on Energy and Commerce of the House and to the Committee on Labor and Human Resources of the Senate the second of two reports concerning recommendation for legislative and administrative actions needed to respond to issues raised by the Task Force on Long-Term Health Care Policies or to improve consumer protection with respect to long-term health care policies. (section 9601 of Public Law 99–272, COBRA)	November 1, 1990
HOME HEALTH PAYMENT	
Secretary of HHS shall submit to Congress a final report on the result of demonstration projects assessing alternative methods of paying home health agencies on a prospective basis for services furnished under the Medicare and Medicaid programs. (section 4027(a) of Public Law 100–203, OBRA87)	December 22, 1991
NURSING HOME STAFFING	
Secretary of HHS shall report to Congress on the progress made in implementing the nursing facility staffing requirements including the number and types of waivers modifying nursing facility staffing requirements which have been approved and the number of facilities which have received waivers. (section 4211(b)(2)(c) of Public Law 100–203, OBRA87)	January 1, 1993
QUALITY OF CARE IN CMI DEMONSTRATIONS	
Secretary of HHS shall report to Congress on the cost, accessibility, utilization, and quality of services provided under chronically mentally ill demonstration waivers. (section 9412(a) of Public Law 99–509, OBRA86)	January 1, 1993

II. SELECTED BIBLIOGRAPHY

A. General Accounting Office Reports

Selected reports prepared by the General Accounting Office from 1983 to the present. Reports are listed in reverse chronology.

U.S. General Accounting Office. Medicaid: little effect from legislative change permitting asset revaluation after sales. Apr. 8, 1988. Washington, G.A.O., 1988. GAO/HRD-88-65, B-223870.2

Pursuant to a legislative requirement, GAO examined whether States changed their Medicaid reimbursement policies to allow revaluation of sold nursing home assets, and the cost effects of any such changes. GAO found that: (1) all States except Alaska provided assurance that ownership changes would not increase Medicaid capital payments; (2) only Alabama, Alaska, and Virginia changed their payment methods regarding asset revaluation; (3) State officials believed that the cost impact of program changes would be minimal because relatively few nursing homes would change hands; (4) many States did not make changes because they believed that changes would affect State program costs; and (5) if additional

States changed their revaluation policies, Medicaid costs would be substantially affected.

——. Medicaid: Early problems in implementing the Philadelphia HealthPASS program. Dec. 22, 1987. Washington, G.A.O., 1987. GAO/HRD-88-37, B-229367

In response to a congressional request, GAO reviewed Pennsylvania's progress and problems in implementing the Philadelphia Accessible Services System (HealthPASS), a contractor-operated program that manages and coordinates delivery of prepaid health care services to Medicaid recipients.

——. Prenatal care: Medicaid recipients and uninsured women obtain insufficient care; report to the chairman, Subcommittee on Human Resources and Intergovernmental Relations, Committee on Government Operations, House of Representatives. Sept. 30, 1987. Washington, G.A.O., 1987. GAO/HRD-87-137, B-229112

"Of the women interviewed, about 63 percent obtained prenatal care that GAO deemed insufficient because they did not begin care within the first 3 months of their pregnancy or made eight or fewer visits for care. Insufficient prenatal care was a problem for women of all childbearing ages, of all races, and from all sizes of communities. Compared with a group of women with private health insurance, Medicaid recipients and uninsured women began care later and made fewer visits."

——. Medicaid: improvements needed in programs to prevent abuse; report to the Secretary of Health and Human Services. Sept. 1, 1987. Washington, G.A.O., 1987. GAO/HRD-87-75, B-228646

"Although GAO and others have previously identified weaknesses in States' postpayment utilization review programs and HHS's oversight, HHS has not taken effective action to strengthen management controls."

——. Medicare and Medicaid: stronger enforcement of nursing home requirements needed. July 22, 1987. Washington, G.A.O., 1987. GAO/HRD-87-113, B-225935

In response to a congressional request, GAO investigated the enforcement of Medicare and Medicaid requirements for nursing homes, focusing on the extent and potential effect of repeated noncompliance and the adequacy of enforcement actions taken by State and federal agencies.

——. Veterans Administration: VA pensions to Medicaid nursing home residents should be reduced; report to the chairman, Committee on Veterans' Affairs, U.S. Senate. July 10, 1987. Washington, G.A.O., 1987. GAO/HRD-87-111, B-225935

"In our ongoing review of the Medicaid program, we noted a situation that significantly increases the government's costs for nursing home care provided to veterans or their survivors who are dually eligible for a Veterans Administration (VA) pension and Medicaid benefits."

——. Medicaid: interstate variations in benefits and expenditures; briefing report to the Honorable Daniel Patrick Moynihan, United States Senate. May 4, 1987. Washington, G.A.O., 1987. GAO/HRD-87-67BR; B-226691

"Identified trends and wide variations among States in Medicaid spending and compared eligibility criteria used, the scope of services offered, and reimbursement to providers; furthermore, compared Medicaid spending in New York with national averages. Finally, reviewed and summarized studies analyzing the underlying causes of the variations identified."

——. Long-term care insurance: coverage varies widely in a developing market. Apr. 29, 1987. Washington, G.A.O., 1987. GAO/HRD-87-80, B-226097

In response to a congressional request, GAO provided information on private long-term care insurance policies, specifically: (1) policy benefits and premiums; (2) policy limitations and restrictions; and (3) the potential for abuse in the market.

——. Medicaid: determining cost-effectiveness of home and community-based services; report to the administrator, Health Care Financing Administration, Department of Health and Human Services. Apr. 28, 1987. Washington, G.A.O., 1987. GAO/HRD-87-61, B-208492

"While HCFA's revised reporting requirements should improve the accuracy of States' program information, GAO recommends that HCFA develop information on the extent to which the program prevents or postpones the need for nursing home care. Without such information, the program's cost-effectiveness cannot be adequately evaluated."

——. Medicaid: addressing the needs of mentally retarded nursing home residents; report to the Secretary of Health and Human Services. Apr. 15, 1987. Washington, G.A.O., 1987. GAO/HRD-87-77, B-226561

"Discusses the Medicaid management controls needed to assure that mentally retarded residents of nursing homes receive the services they need to help them function independently."

——. Medicare and Medicaid: effects of recent legislation on program and beneficiary costs; report to the Chairman, Select Committee on Aging, House of Representatives. Apr. 8, 1987. Washington, G.A.O., 1987. GAO/HRD-87-53, B-226390

"Discusses the effects of major legislation since 1980 on Medicare and Medicaid program costs and on beneficiary out-of-pocket costs."

——. Medicaid: lessons learned from Arizona's prepaid program; report to the Secretary of Health and Human Services. Mar. 1987. Washington, G.A.O., 1987. GAO HRD-87-14; B-220864

"One experiment to limit Medicaid costs is Arizona's Health Care Cost Containment System, under which the State contracts with prepaid health plans to provide comprehensive medical care for a set monthly fee per patient. GAO reviewed the program's first 3 years of operation . . . to examine Arizona's approach to competitive bidding for procuring health plan contracts, collection of utilization data from the prepaid plans on the health care services provided, and financial oversight of the prepaid health plans."

——. Medicaid: results of certified fraud control units. Oct. 21, 1986. Washington, G.A.O., 1986. GAO/HRD-87-12FS, B-224911

In response to a congressional request, GAO reviewed State-certified Medicaid fraud control units to determine: (1) their expenditures for fiscal years 1984 and 1985, including Federal and State governments' share of the expenses; (2) their results, including convictions, fines and restitution, and overpayments identified; and (3) changes that could strengthen their fraud control efforts.

——. Managing welfare: issues and alternatives for reforming quality control systems. Aug. 29, 1986. Washington, G.A.O., 1986. GAO/HRD-86-117BR, B-219254

In response to a congressional request, GAO reviewed the quality control systems States use to administer the Aid to Families with Dependent Children (AFDC), Medicaid, and Food Stamp programs.

——. Medicaid: methods for setting nursing home rates should be improved; report to the Secretary of Health and Human Services. May 1986. Washington, G.A.O., 1986. GAO/HRD-86-26, B-221534

"Reviewed the prospective payment systems in seven States: Arkansas, Georgia, Illinois, Kentucky, Minnesota, South Carolina, and Texas" in order to determine "how effective have States been in establishing prospective payment systems that provide nursing homes an incentive to reduce costs without adversely affecting quality of care."

——. Improved efforts needed to relieve Medicaid from paying for services covered by private insurers; report to the Congress by the Comptroller General of the United States. Feb. 12, 1985. Washington, G.A.O., 1985. GAO/HRD-85-10, B-204545

Concludes that "Medicaid, a federally aided, State-administered medical assistance program for low-income people, should be relieved of health care costs if some other party is legally responsible to pay. Nevertheless, States receive bills for Medicaid recipients who have coverage under health and liability insurance. State Medicaid administrative systems often do not identify the liable insurers or redirect these medical bills to them."

——. Expanded Federal authority needed to protect Medicare and Medicaid patients from health practitioners who lose their licenses; report to the Secretary of Health and Human Services. May 1, 1984. Washington, G.A.O., 1984. GAO/HRD-84-53, B-214207

"Overall, GAO identified several gaps in HHS' exclusion authority which can result in, among other things, practitioners who are excluded from either Medicare or Medicaid continuing to participate in the other program or practitioners who lost their licenses to practice in one State relocating to another State and participating in the programs."

——. Medicaid and nursing home care: cost increases and the need for services are creating problems for the States and the elderly; report to the Chairman of the Subcommittee on Health and the Environment, Committee on Energy and Commerce, House of Representatives. Washington, G.A.O., 1983. GAO/IPE-84-1, Oct. 21, 1983

"This review raises questions about whether State Medicaid nursing home programs have an incentive to use the health care system efficiently, if all persons needing Medicaid nursing home services have access to them, and if sufficient information will be available to plan effectively for the long-term care needs of the elderly population."

——. Changing Medicaid formula can improve distribution of funds to States; report to the Congress by the Comptroller General of the United States. Washington, G.A.O., 1983. GAO/GGD–83–27, Mar. 9, 1983

"The formula used to establish Federal reimbursement rates for State Medicaid spending is not as equitable to States as it could be. This is because per capita income—a key formula factor—does not adequately reflect the greater tax burden of States with a high proportion of the needy and because it is not the best available measure of States' ability to finance Medicaid from State revenue sources. The formula also contributes to the wide disparity in benefits provided under State Medicaid programs."

——. Improving Medicare and Medicaid systems to control payments for unnecessary physicians' services; report to the Congress by the Comptroller General of the United States. Feb. 8, 1983. Washington, G.A.O., 1983. GAO/HRD–83–16, B–207363

"Some services provided to Medicare and Medicaid recipients by physicians or suppliers are medically unnecessary and, under the law, should not be paid for by these programs. This report discusses the systems to identify, prevent, or recover payments for unnecessary services and describes how they can be improved to reduce program costs."

B. HEALTH CARE FINANCING ADMINISTRATION DOCUMENTS

U.S. Department of Health and Human Services. Health Care Financing Administration. Office of the Actuary. Program statistics: Analysis of State Medicaid program characteristics, 1986. Washington, U.S. Govt. Print. Off., Aug. 1987. HCFA Pub. No. 03249

"Reflects State Medicaid profiles as of March 31, 1986, and contains the following types of information on a State-by-State basis: State eligibility policies; service coverage and limitations; provider reimbursement policies; administration and finance characteristics; demographic, economic, and medical sector characteristics; and State-only programs."

——. Office of Research and Demonstrations. Grant and contracts report: A decade of Medicaid experience, fiscal years 1973 through 1982. Washington, U.S. Govt. Print. Off., Sept. 1985 HCFA Pub. No. 03216

"The primary goal of this report is to assist public officials and researchers to become better informed about Medicaid expenditure trends and the differences in growth for particular services, by eligibility class, by State and for subperiods of the decade. A second goal is to relate contextual influences (such as the general inflation in medical care prices) and changes in program characteristics to the recent and longer-run expenditure trends. A fairly dramatic slowdown of Medicaid expenditure growth in fiscal year 1982 was observed in many of the States. The possible links between this development and specific program changes by Federal and State governments will receive special attention."

——. Office of Research and Demonstrations. Health Care Financing Review. Vol. 1– , Summer 1979– . Washington, U.S. Govt. Print. Off.

This quarterly research journal focuses on research, demonstrations, and statistical findings in the area of health care financing. It was established as the principal mechanism for communicating HCFA's findings to the Congress, Federal, State, and local officials, as well as to health planners, health care providers, health care insurers, researchers, and the general public.

——. Office of Research and Demonstrations. Program statistics 1986: Medicare and Medicaid databook. Washington, U.S. Govt. Print. Off., Sept. 1987. HCFA Pub. No. 03247

This databook "provides an overview of the Medicare and Medicaid programs. This report presents basic data and analyses of the programs. It includes trends on enrollees, recipients, use of services and expenditures, and describes various aspects of the two programs. It also provides lists of Medicare agencies and fiscal agents, and Agency offices to call for information."

——. Office of Research and Demonstrations. Status Report: Research and Demonstrations in Health Care Financing. Washington, U.S. Govt. Print. Off., Jan. 1988. HCFA Pub. No.03253

"The Office of Research and Demonstrations, Health Care Financing Administration (HCFA), directs nearly 300 research, evaluation, and demonstration projects . . . This report provides basic information on active intramural and extramural projects in a brief format."

——. Task Force on Technology-Dependent Children. Report to Congress and the Secretary. *Fostering Home and Community-Based Care for Technology-Dependent Children.* 2 vols. Washington, U.S. Govt. Print. Off., April 1988. HCFA Pub. No. 88–02171

". . . the Task Force conducted a comprehensive 18 month examination of barriers that prevent the provision of appropriate care in a home or community setting. Also, it examined changes necessary in the provision and financing of health care in private and public health care programs to foster home and community-based alternatives to the institutionalization of technology-dependent children."

C. OFFICE OF TECHNOLOGY ASSESSMENT REPORTS

U.S. Congress, Office of Technology Assessment. Healthy children: investing in the future. Washington, D.C., U.S. Govt. Print. Off., Feb. 1988. OTA–H–345

"Fortunately, most children in the United States enjoy excellent health, but this assessment demonstrates that greater strides toward improvement in their well-being are still possible if more emphasis is placed on cost-effective prevention

strategies. . . . OTA has identified several preventive strategies for improving American children's health, some of which would be clearly cost-saving to the U.S. health care system, some of which are effective (though not cost-saving), and some of which hold promise of having important impacts on children's health [including but not limited to] improved access to early prenatal care for poor women, . . . comprehensive school-based clinics for adolescents at high risk of unwanted pregnancy, . . . newborn screening, . . . well-child care as often as required for full immunization of young children, . . . and improved access to physicians' services for children living at or near the poverty level."

——. Indian Health Care. Washington, D.C., U.S. Govt. Print. Off., April 1986. OTA–H–290

"The health status of Indian people still lags behind the health status of the general U.S. population, and there are substantial differences in health status and causes of illness among the nearly 300 Indian tribes and the more than 200 Alaska Native villages in the United States...This report is an assessment of health care for American Indians and Alaska Natives who are eligible for medical and health-related services from the Federal Government."

——. Technology-dependent children—hospital v. home care: a technical memorandum. Washington, D.C., U.S. Govt. Print. Off., May, 1987. OTA–TM–H–38

"Recent advances in medical technology have permitted sick children who once would have died to survive with the assistance of sophisticated equipment and intensive nursing care. . . . As technology for helping keep children alive has improved, a new population of technology-dependent children has emerged. . . . This technical memorandum provides a working definition of technology dependence and estimates the prevalence of technology dependence among American children. A principal finding is that the size of the population varies dramatically with the clinical criteria used in the definition. OTA has also found that the cost-saving potential of home care depends to a great extend on attributes of the family and the home environment."

D. CONGRESSIONAL RESEARCH SERVICE MATERIALS

U.S. Library of Congress. Congressional Research Service. Medicaid: fiscal year 1989 budget; issue brief by Mark Merlis. [Washington] Updated regularly. CRS Issue Brief IB88026

On Feb. 18, 1988, the President transmitted to Congress the proposed fiscal year 1989 budget. No legislative changes in Medicaid were included, on the grounds that basic fiscal year 1989 Medicaid policies were established by the 2-year budget agreement arrived at by the Administration and Congress in November. However, the Administration plans regulatory and administrative changes intended to reduce Federal Medicaid outlays by $413 million in fiscal year 1989.

——. Financing and delivery of long-term care services for the elderly, by Carol O'Shaughnessy and Richard Price. [Washington] May 25, 1988. CRS Report 88–379 EPW

This report provides an overview of information on these two major issues in long-term care—(1) the potentially catastrophic expenses elderly persons can incur as the result of chronic illness or disability and (2) the need and demand for additional home and community-based care. It includes information on characteristics of the elderly and their utilization of long-term care services as well as their projected utilization of services in the future. It also reviews public sector programs that support long-term care and private sector approaches that have been suggested in the past few years as feasible alternative for financing this care.

——. Community-based services for individuals with severe disabilities: summary and analysis of S. 1673 and H.R. 3454, by Mary F. Smith. [Washington] Mar. 14, 1988. CRS Report 88–212 EPW

Legislation has been introduced in the 100th Congress that would require States to deliver specified community-based services under the Medicaid program for persons with severe disabilities. The proposed legislation would limit most Medicaid funding for large residential facilities to current expenditure levels. This paper summarizes the proposed legislation, presents program participation and expenditure data under existing law, and discusses major issues regarding the proposed provisions.

——. Medicaid eligibility for the elderly in need of long term care, by Edward Neuschler and Claire Gill. [Washington] Sept. 1987. CRS Report 87–986 EPW

The purpose of this report is to begin to explore the process by which elderly persons become eligible for skilled and intermediate nursing home care under Medicaid. Based on a survey of 50 States' Medicaid programs, the report discusses the basic criteria elderly people must meet in order to become eligible for Medicaid and presents limited information on the availability of nursing home beds and on the process by which the need for nursing home care is certified. State and Federal rules governing the income and assets of the noninstitutionalized spouse of a Medicaid nursing home resident are also discussed.

——. Medicaid: spousal impoverishment, by Jennifer O'Sullivan. [Washington] July 31, 1987. CRS Report 87–648 EPW

As a result of Medicaid rules, both for determining eligibility and in the treatment of income after eligibility has been established, the spouse residing in the community may become impoverished; this is referred to as "spousal impoverishment." This paper provides background information on the spousal impoverishment issue.

——. Work incentives for disabled Supplemental Security Income (SSI) recipients: section 1619 of the Social Security Act, by Carmen D. Solomon. [Washington] May 18, 1987. CRS Report 87–427 EPW

Before 1980, when a disabled person's counted income exceeded the substantial gainful activity (SGA) amount, his Supplemental Security Income (SSI) benefit was ended. In many

States, this caused the loss of Medicaid benefits as well. Critics of these SSI policies argued that the program was discouraging disabled recipients from seeking employment. This paper discusses in detail section 1619 of the Social Security Act, designed to encourage disabled SSI recipients to work.

——. Medicare, Medicaid, and maternal and child health programs: an overview of major legislation enacted from 1980 through 1986, by Janet Kline, Jennifer O'Sullivan and Joseph A. Cislowski. [Washington] Apr. 3, 1987. CRS Report 87-296 EPW

This report traces the major Medicare amendments which have affected hospitals, physicians, and beneficiaries since 1980. It also reviews the major Medicaid amendments affecting Federal financial participation in the program, coverage of pregnant mothers and children, as well as those amendments designed to give States increased flexibility in administering their programs. Lastly, the report describes the consolidation of Federal health service programs for mothers and children under a new block grant authority.

——. Medicare, Medicaid, and other health provisions of the "Consolidated Omnibus Budget Reconciliation Act of 1985" Public Law 99-272 (known as COBRA), by Jennifer O'Sullivan. [Washington] Dec. 29, 1986. CRS Report 86-196 EPW

On April 7, 1986, the President signed into law the "Consolidated Omnibus Budget Reconciliation Act of 1985" (referred to as COBRA). This legislation includes a number of spending reduction provisions for Medicare as well as other modifications to both the Medicare and Medicaid programs. This report provides a background description of the Medicare and Medicaid programs, a legislative history of COBRA, and a summary of the relevant provisions of the Act.

——. Services for persons with mental retardation and developmental disabilities: background information and discussion of issues, by Mary F. Smith and Richard Price. [Washington] Sept. 16, 1986. CRS Report 86-898 EPW; CP 2157

The major source of Federal support for persons with mental retardation and developmental disabilities is the Medicaid program, title XIX of the Social Security Act. This paper describes Medicaid services and other Federal programs serving this population and discusses issues in the delivery of services to these persons.

——. Medicaid "2176" waivers for home and community-based care, by Carol O'Shaughnessy and Richard Price. [Washington] June 21, 1985. CRS Report 85-817 EPW

"The Medicaid Home and Community-Based Services Program, also referred to as the "2176 waiver program," was authorized under Section 2176 of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (Public Law 97-35). The legislation allows the Secretary of Health and Human Services (HHS) to waive certain Medicaid requirements to allow States to provide a variety of home and community-based long term care services to individuals who would otherwise require the level of care provided in a skilled nursing facility (SNF) or intermediate care facility (ICF). . . . This report presents background on

the 2176 home and community-based waiver program, including legislative history, a summary of implementing regulations, an overview of types of waivers granted, and case examples of waivers, and issues raised by waivers."

——. Medicare and Medicaid provisions of the "Deficit Reduction Act of 1984" (Public Law 98-369), by Jennifer O'Sullivan. [Washington] Jan. 11, 1985. CRS Report 85-27 EPW

"The major portion of this report provides a background description of the Medicare and Medicaid programs, a legislative history of Public Law 98-369 (the Deficit Reduction Act of 1984), and a summary of relevant provisions of the Act. The report also includes a brief summary of relevant provisions of Public Law 98-617."

——. Medicare and Medicaid provisions of the "Tax Equity and Fiscal Responsibility Act of 1982" (Public Law 97-248), by Jennifer O'Sullivan and Glenn Markus. [Washington] Oct. 6, 1982. CRS Report 82-173 EPW

"On Sept. 3, 1982, the President signed into law Public Law 97-248, the "Tax Equity and Fiscal Responsibility Act of 1982." The new law contains a number of amendments to the Medicare and Medicaid programs which are summarized in this report."

——. Medicare and Medicaid provisions of the "Omnibus Budget Reconciliation Act of 1981" (Public Law 97-35), by Jennifer O'Sullivan. [Washington] Sept. 11, 1981. CRS Report 81-210 EPW

"On August 13, 1981, the President signed into law Public Law 97-35, the "Omnibus Budget Reconciliation Act of 1981." The new law contains a number of amendments to the Medicare and Medicaid programs which are summarized in this report."

E. CONGRESSIONAL HEARINGS

U.S. Congress. House of Representatives. Select Committee on Aging. Less Profit, Less Care? Reassessing the Impact of Medicare and Medicaid Cuts on Patients. Hearings, 100th Congress, 2nd session. Comm. Pub. No. 100-667. Washington, U.S. Govt. Print. Off., 1988.

——. House of Representatives. Select Committee on Aging. Medicare and Medicaid Reform: Protecting the Aged and Indigent in Texas. Hearings, 99th Congress, 2nd session. Comm. Pub. No. 99-532. Washington, U.S. Govt. Print. Off., 1985.

——. House of Representatives. Committee on Energy and Commerce. Subcommittee on Health and the Environment. Medicare and Medicaid Issues. Hearings, 99th Congress, 1st session. Comm. Pub. No. 99-19. Washington, U.S. Govt. Print. Off., 1985.

——. Senate. Committee on Finance. Medicare, Medicaid, and Maternal Health Block Grant Budget Issues, Part 2. Hearings, 100th Congress, 1st session. S. Hrg. 100-398, Pt. 2. Washington, U.S. Govt. Print. Off., 1987.

——. Senate. Committee on Finance. Medicare, Medicaid, and Maternal Health Block Grant Budget Issues. Hearings, 100th Congress, 1st session. S. Hrg. 100–398, Pt. 1. Washington, U.S. Govt. Print. Off., 1987.

——. Senate. Committee on Finance. Medicare and Medicaid. Hearings, 100th Congress, 1st session. S. Hrg. 100–19. Washington, U.S. Govt. Print. Off., 1987.

——. Senate. Committee on Finance. Medicaid Third-Party Liability Collections. Hearings, 99th Congress, 1st session. S. Hrg. 99–32. Washington, U.S. Govt. Print. Off., 1985.

——. Senate. Committee on Finance. Subcommittee on Health. Medicaid Financing of Services for Developmentally Disabled Persons. Hearings, 99th Congress, 2nd session. S. Hrg. 99–1043. Washington, U.S. Govt. Print. Off., 1986.

F. Office of the Inspector General Reports

U.S. Department of Health and Human Services. Office of the Inspector General. Office of Analysis and Inspections. Sheltered Workshop Services Provided Residents of Intermediate Care Facilities for the Mentally Retarded. Washington, D.C. Nov. 1986. P–09–86–00048

"When OAI questioned the States that provide sheltered workshop services, we found that there was little agreement on the definition of 'vocational training' for Medicaid reimbursement purposes. Twenty-three States claimed FFP for sheltered workshop services and were erroneously paid an estimated $27 million in Federal funds."

——. AFDC, Medicaid, and Food Stamp Administrative Costs. Washington, D.C. Dec. 1986. OAI–05–86–00008

"The OAI initiated this study because of the wide variation among States in the cost of administering the AFDC, Medicaid, and Food Stamp programs. In fiscal year 1984 the combined Federal share of administrative costs per recipient ranged from $22 to $151. Despite a number of proposed reasons for the difference, OAI found no logical set of explanations for the variance other than relative State efficiency."

——. Medicaid Managed Health Care Programs. Washington, D.C. Feb. 1987. OAI–07–86–00040

"The OAI inspection described the various State-implemented programs and their perceived effectiveness in terms of meeting the medical needs of the beneficiaries enrolled in the managed care programs . . . Over 80 percent of beneficiaries and physicians that were interviewed believe that the quality of care is the same or better under the managed care programs."

——. Oversight of State Medicaid Fraud Control Units. Washington, D.C. June 1987. OAI–01–87–00015

An investigation was conducted to determine how the OIG's Office of Investigation (OI) might use performance indicators to determine the effectiveness of State Medicaid Fraud Control Units (MFCU's) and how OI might use minimum staffing requirements as a measure of effectiveness. "The OAI found strong general support for performance indicators, though a number of concerns were raised by the MFCU directors about

how OI might use the indicators when making judgments about individual MFCU's."

G. OTHER REPORTS AND JOURNAL ARTICLES

Affording access to quality care: strategies for State Medicaid cost management. Washington, National Governors' Association, June 1986. Pub. No. 3040

"A comprehensive analysis of State Medicaid policy alternatives to address cost, access, and quality concerns. Individual chapters . . . focus on: eligibility options; services and delivery setting for material and child health; management of inpatient hospital expenditures; outpatient prescription drugs; physician reimbursement; and alternative financing and delivery systems."

Broadening Medicaid coverage of pregnant women and children: State policy responses. Washington, National Governors' Association, Feb. 1987. Pub. No. 3069

"An overview and descriptive analysis of federal statutory changes and State policy responses related to expanded Medicaid coverage options for pregnant women and children. Information on States' conditions of eligibility is presented, including an update outlining which States are extending special eligibility levels to this population and current AFDC, SSI and medically needy standards."

Desonia, Randolph A. and Kathleen M. King. State programs of assistance for the medically indigent. Springfield, Va. Intergovernmental Health Policy Project, George Washington University, 1986. HRP–0906759

Identifies and documents "the major State policies and programs designed to improve access to health care for the medically indigent."

Erdman, Karen and Sidney M. Wolfe. Poor health care for poor Americans: a ranking of State Medicaid programs. Public Citizen Health Research Group. Washington. 1987.

"This report attempts to answer the question, "If I were a poor person living in the United States, in which State would I have the best chance of gaining access to quality care through the Medicaid program?" In answering this question, it gives a full account of the inequities resulting from the huge variations among the five major areas of State Medicaid program: variations in eligibility policy, scope of services, availability of providers, quality of services, and reimbursement systems. This is the first report to rank Medicaid programs on the basis of comprehensive data concerning all aspect of the program. This report also investigates the reasons for these gross inequities among the States, and make recommendations for Medicaid reform."

Hawes, Catherine, and Charles D. Phillips. The changing structure of the nursing home industry and the impact of ownership on quality, cost, and access. In: For profit enterprise in health care. Institute of Medicine. National Academy of Sciences. Washington, National Academy Press, 1986. p. 492–541.

"This paper . . . explore[s] what is known about the impact of ownership and the corporatization of health care in the nursing home industry. It . . . discuss[es] the history of nursing homes, identif[ies] the current structure of the industry and the public policies that have contributed to this structure, and indicate[s] potential results if current ownership trends persist. Finally, it . . . attempt[s] to apply what is known about developments in nursing homes to the hospital sector."

Institute of Medicine. Committee for the Oversight of AIDS Activities. Confronting AIDS: Update 1988. Washington, National Academy Press, 1988.

"This report presents the committee's findings and the recommendations that arose from them. It should be viewed as an update of and a supplement to *Confronting AIDS:* it makes no attempt to duplicate the breadth and depth of information available in the original report."

——. Committee on Nursing Home Regulation. Improving the Quality of Care in Nursing Homes. Washington, National Academy Press, 1986

Concludes that (1) quality of care and quality of life in many nursing homes is unsatisfactory, (2) more effective government regulation can substantially improve quality, (3) a stronger federal role is necessary, (4) specific improvements are needed in the regulatory system, (5) opportunities exist to improve the quality of care independently of changes in Medicaid payment policy or bed supply, (6) regulation is necessary but not sufficient for high-quality care, (7) there should be a system to obtain standardized data on residents, and (8) the regulatory system should be flexible and evolutionary in outlook.

——. Committee to Study the Prevention of Low Birthweight. Preventing low birthweight. Washington, National Academy Press, 1985.

"Defines and describes the significance of low birthweight, the data on etiology and risk factors, and describes the significance of low weight, the data on etiology and risk factors, and recent State and national trends in the incidence of low birthweight among various groups and describes the preventive approaches found more desirable and considers their costs."

Lipson, Debra J., Rhona S. Fisher, and Constance Thomas. Major changes in State Medicaid and indigent care programs. Intergovernmental Health Policy Project. Washington, Jan.–Aug. 1987.

"Contains up-to-date information on recently adopted State policies affecting eligibility, benefits, reimbursement practices, and administration and management of State Medicaid programs. It also summarizes recent State initiatives and demonstration projects in both Medicaid and indigent care programs."

Medicaid contracts with HMO's and prepaid health plans: a handbook for State managers. Washington, National Governors' Association, Nov. 1987

"A detailed manual that addresses specific, pragmatic concerns crucial to the success of prepaid health care arrangements for Medicaid recipients. Major topics include: provider qualification, rate setting and other contract issues, marketing and enrollment systems, quality monitoring, and contract management issues."

President's Commission on the Human Immunodeficiency Virus Epidemic. Report of the President's Commission on the Human Immunodeficiency Virus Epidemic. Washington, U.S. Govt. Print. Off., June 1988.

"The recommendations of the Commission seek to strike a proper balance between our obligation as a society toward those members of society who have HIV and those members of society who do not have the virus, to slow or stop the spread of the virus , to provide proper medical care for those who have contracted the virus, and to protect the rights of both infected and noninfected persons requires a careful balancing of interests in a highly complex society."

Restructuring Medicaid: an agenda for change: summary report of the National Study Group on State Medicaid Strategies. Washington, Center for the Study of Social Policy, 1983.

"The National Study Group on State Medicaid Strategies was formed in the fall of 1982 to explore alternative directions to provide publicly supported health care for the poor. The formation of the National Study Group, composed of nine State Medicaid, Public Health and Human Service Administrators, reflects a growing concern about public support of health care for the poor. In recognition of the severe fiscal and programmatic pressures placed on State Medicaid and related health programs, the Study Group's mission was to establish a new agenda for change that offers promise of controlling rapidly rising costs and improving access to and quality of needed health care services." An executive summary lists major recommendations.

Southern Regional Task Force on Infant Mortality. Final report: for the children of tomorrow. Nov. 1985.

Reports on the Task Force's recommendations and findings concerning theses goals: "taking steps to raise public awareness of the severe nature of infant mortality and low birthweight in the South and of the potential which exists for instituting effective preventive measures; reporting on the status of infant mortality in the South and the current efforts to reduce it; identifying preventive approaches to reducing infant mortality and low birthweight which have been successful within the South, in other parts of the country, and internationally; recommending steps which key policy makers and health care practitioners in the region must take to substantially improve the health of pregnant women and young infants in the South."

Squarrell, Karen I., Suzanne M. Hansen, and Edward Neuschler. Prepaid and managed care under Medicaid: characteristics of current initiatives. Washington, National Governors' Association, Oct. 1985.

"This report describes State initiatives in the areas of prepaid health care and primary care case management for the Medicaid population, for acute and routine care only. . . . The report consists primarily of detailed summaries of the various

State initiatives. . . . [the] overview introduces the concept of managed health care and orients the reader to the key design features of the various State initiatives."

Toff, Gail E. Mental health benefits under Medicaid: a survey of the States. Washington, Intergovernmental Health Policy Project, George Washington University, 1984.

"Although States may not discriminate on the basis of diagnosis, they are free to set both dollar and usage limitations on the amount, duration, and scope of Medicaid coverage. Because of this, as well as the restrictions on inpatient care and the optional status of many mental health benefits, uniform Medicaid coverage is not available to the nation's mentally ill poor. As the following report indicates, many States have in fact imposed special limitations on mental health care including: prior authorizations; physician supervision requirements; restrictions on the number of visits; and special rate limits."

APPENDIXES

APPENDIX A. MEDICAID AND THE POOR [1]

I. INTRODUCTION

A. Summary

Medicaid is the largest government health program financing medical care for the poor. But, as earlier chapters of this report have pointed out, not all of the poor are beneficiaries of Medicaid, and not all Medicaid beneficiaries are poor. Roughly 41 percent of the poor (individuals with incomes below the Federal poverty threshold) were covered by Medicaid in 1986. Approximately 24 percent of those with Medicaid had family incomes above the poverty threshold.

This appendix provides estimates of Medicaid coverage of the poor and near-poor (individuals with incomes less than 200 percent of Federal poverty thresholds). It focuses on who among the poor and near-poor are covered by Medicaid or other forms of health insurance. Some of the more important findings are:

—Roughly 41 percent of the poor are covered by Medicaid, another 26 percent are covered by other forms of health insurance. While, one-third of the poor have no health insurance;

Medicaid eligibility rules result in different individuals facing different income limits:

—The maximum income a family with children can have and still be eligible for Medicaid coverage varies by the State an individual lives in, whether anyone in the family is employed, and how long they have been employed. In 1988, the maximum allowable income for a family of 3 varies from 15 to 147 percent of the poverty line;

—The maximum income for an aged or disabled individual does not vary as much as the income limits for families with children. In 1988, the maximum allowable income for aged or disabled individuals ranges from 78 to 160 percent of the poverty line;

Medicaid eligibility rules limit who among the poor can be covered:

—Seven percent of the poor are people living in families with children, but they are individuals not likely to be considered as part of the family unit eligible for Medicaid. This group includes some children over 18 and other relatives.

Medicaid income limit eligibility rules affect who among the poor are likely to be covered. Families facing severe poverty have a greater chance of being covered than families with incomes closer to the poverty threshold:

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[1] This appendix was written by Richard Rimkunas. Computer graphics were prepared by Keith Hurt.

—Close to 6 out of 10 people in families with income (excluding cash assistance payments) less than half of the poverty threshold are covered by Medicaid. Slightly more than 1 out of 5 people with incomes between 50 and 100 percent of poverty (excluding cash assistance payments) are covered by Medicaid (see figure A-1);

Medicaid eligibility rules do allow people with incomes above the poverty threshold to be covered:

—Roughly 24 percent of those people who said they had Medicaid coverage had family income (excluding cash assistance payments) above the Federal poverty threshold. Generally, these are elderly or disabled people incurring extremely high medical expenses. However, the likelihood of Medicaid coverage declines very rapidly as a family's income increases;

—Despite the important role Medicaid plays in providing health insurance coverage for the poor and near-poor, this low-income group represents about 60 percent of all people without health insurance;

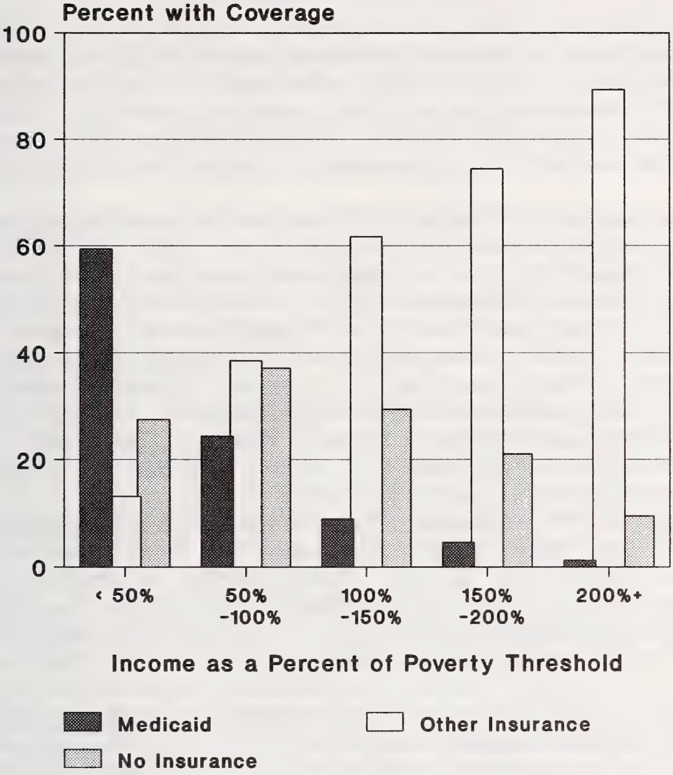
Whether a poor or near-poor person is covered by Medicaid depends on whether the individual meets the criteria associated with the program's needs test. There are two sets of factors associated with Medicaid's needs test: the first determines who among the poor are potentially eligible; the second includes an explicit test of income to determine if the level of poverty faced by the individual is severe enough to qualify for the program. While this appendix focuses on an individual's family income and whether the individual is covered by Medicaid, a large number of people will not be covered by Medicaid because they don't meet the first eligibility factor. For example, most persons without children and nonaged able-bodied individuals will be ineligible for Medicaid since they fail to fall into any of the categories of potential Medicaid coverage.

Medicaid coverage of the poor varies from State-to-State, by the person's family type, and by the amount and source of an individual's family income and resources. These factors all play an important role in the coverage of the poor as a result of Medicaid's link to the cash assistance programs found in the Social Security Act, in particular the Aid to Families with Dependent Children (AFDC) program, and Supplemental Security Income (SSI) program.

The eligibility rules for these cash assistance programs are complex and the income limits associated with the rules do not coincide with commonly used definitions of poverty. As a result, in some States individuals with income in excess of the poverty line are eligible for assistance, in other States individuals with incomes well below the poverty line are not.

This appendix clarifies who the poor are, why some are eligible for Medicaid, and why others are not. The first part of the appendix describes how poverty is defined, how likely individuals in certain demographic groups are to be poor, and the makeup of the poor population. The second part of the appendix describes the relationship between Medicaid, the poor, and near-poor. It briefly describes the eligibility rules associated with AFDC and SSI, the income limits for these programs and how these limits are related to the poverty level. It concludes with estimates of Medicaid coverage rates for the poor based on an analysis of the Current Popula-

Figure A-1
Health Insurance Coverage Rates,
By Income, 1986



Note: Income excludes cash welfare payments

Source: March 1987 Current Population Survey

tion Survey (CPS). Since many of the nonpoor are also eligible for Medicaid, the third section of the appendix provides a demographic profile of these individuals. The final section of the appendix provides information on individuals who have no health insurance.

B. LIMITATIONS OF ESTIMATES

The estimates of Medicaid coverage by family income in this appendix are based on information contained in the March 1987 CPS. Among other items, this survey asks questions on family income and health insurance coverage. Retrospective reporting of the family's income and health insurance coverage during 1986 is provided by each respondent. There are some important limitations to these data.

First, since the CPS relies on retrospective reporting of an individual's health insurance coverage for any time during the last year, it does not allow us to provide any details on dual insurance coverage.[2] We can determine whether an individual had more than one form of health insurance in 1986, but there is no way to determine if the forms of coverage occurred at the same time. For many of the poor, Medicaid was their only source of health insurance in 1986, but all aged respondents with Medicaid coverage also responded they had Medicare coverage. The aged are likely to have dual coverage (see Appendix C), but the CPS can not provide us with accurate information on this issue.

Second, the CPS estimates of income and program recipiency are generally less than comparable estimates from administrative records and other sources. This underreporting of program receipt and income is the result of a number of factors. For the Medicaid population, one important factor is that the CPS provides estimates of the noninstitutionalized civilian population. According to program data, roughly 7 percent of Medicaid beneficiaries in fiscal year 1986 received services in nursing homes (skilled nursing facilities (SNF) or intermediate care facilities (ICF)) or intermediate care facilities for the mentally retarded (ICF/MR). Disabled and aged individuals receiving these type of Medicaid services are not likely to be found in the CPS sample. Differences in Medicaid coverage using the CPS as compared to other sources may also come as a result of individuals failing to report health insurance coverage, or incorrectly reporting this information. No attempt has been made to adjust survey responses for this underreporting.

Third, the CPS estimates contained in this appendix are based on a national sample.[3] As a result they may differ from the figures that would have been obtained if a census had been taken. Since the figures are based on a sample they are only estimates and some degree of sampling error is associated with them. The degree of error associated with the estimates increases as the number of respondents in a category decreases. One result of this sampling is that State-by-State estimates of the poor population, or the Medicaid population estimate would not be reliable.[4] This is an important limitation since there is a substantial amount of variability in who is eligible for Medicaid from State to State.

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[2] Some analysts have argued that respondents of the Current Population Survey provide information on their health insurance coverage at the time of the interview, rather than the lengthy retrospective reporting period implied by the question. This perspective is based on a comparison of estimates from the CPS and other surveys. Since many factors can account for these inter survey differences, this comparison is inconclusive. The estimates presented in this appendix assume that respondents answered the health insurance questions correctly.

[3] All estimates from the Current Population Survey contained in this appendix exclude roughly 235 thousand children under 15. These children live alone or without any relatives. The March 1987 Current Population Survey does not present income or health insurance status information on these children. Leaving them in the analysis would inflate the number of uninsured. Some of these children are likely to be foster children and potentially eligible for Medicaid coverage (see Chapter II).

II. WHO ARE THE POOR

A. DEFINING POVERTY

Using information from the CPS, the Census Bureau estimates the number of poor based upon a family's annual pretax cash income. Cash income includes income from earnings, interest, public and private pensions, child support and alimony; income from social insurance programs like social security and unemployment compensation; and income from cash assistance programs like AFDC, and SSI.

Individuals are considered to be poor when their family's annual pretax cash income is below a predefined poverty threshold.[5] The poverty threshold is a statistical measure that attempts to indicate the level of cash income needed by a family to purchase a "minimally adequate" market basket of goods and services on an annual basis.[6] The threshold is adjusted for family size and updated each year for inflation. While the cost of living may vary from location to location, the poverty thresholds do not; the threshold is a nationwide standard of poverty. Using the poverty thresholds, a family of three would have to have an income level below $9,056 ($755 per month) to be considered poor in 1987. All estimates of the number of poor contained in this appendix are based on these Census Bureau poverty thresholds.

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[4] State level estimates of the poor are estimated by the Census Bureau with each Decennial Census. The sampling methods used with the Current Population Survey does allows for some State level estimates of the poverty population. However, these estimates are subject to wide confidence intervals and estimates providing detailed demographic characteristics or program participation of the poor at the State level are not possible.

[5] Concerns have been raised that only counting the pretax cash income of a family provides an incomplete picture of its economic status. Some critics of the current definition argue that the failure to count noncash benefits, like Medicaid and Food Stamps, ignores an important kind of income that alleviates some hardships of low-income persons. Alternative approaches for the measurement of poverty have been suggested. These alternatives determine a value of the in-kind benefits and add this to a family's cash income.

There has been considerable debate over what types of income are appropriate to count. Of particular importance, is whether employer provided health benefits, government benefits—like Medicaid and Medicare, and free or uncompensated health care should be included in the income definition. Inclusion of some value of Medicaid and other health benefits will likely have a strong effect on poverty counts and rates. For example, estimates of poverty that include the valuation of Medicare and Medicaid have reduced poverty rates for selected demographic groups by three-fourths.

However, there are a number of questions that still remain about whether to treat health benefits as income. For example, the current methods of valuing health benefits appear to be inconsistent. Some analysts only include government provided benefits, but not employer provided benefits. In addition, it is extremely difficult to compare the comprehensiveness of services covered in health insurance plans and therefore difficult to estimate their value. Since these and other questions are still unresolved, the official definition of poverty has continued to rely on pretax cash income.

[6] Originally developed in the early sixties, the threshold represented three times the annual cost of the U.S. Department of Agriculture's (USDA) 1961 Economy Food Plan. The USDA economy food plan specified quantities of food groups that together met nutritional goals (Recommended Daily Allowances). The multiplier used in building the threshold is based on a 1955 USDA food consumption survey that found, on average, food costs represented one-third of a family's after-tax cash income.

While this comparison of family income to the poverty threshold will be used in our estimates of the poverty population, families with incomes below the poverty threshold do not automatically become eligible for needs-tested benefit programs. These poverty thresholds are not used to determine eligibility for Medicaid or any cash assistance programs.

A simplified version of these Census Bureau statistical thresholds are prepared by the Secretary of Health and Human Services (DHHS) to be used in the administration of a number of means-tested programs.[7] These DHHS income levels are usually referred to as the "Federal poverty income guidelines." [8] As noted in chapter II, some optional and mandatory categories of Medicaid eligibility are directly tied to these guidelines.

Table A-1 displays the 1987 Census Bureau poverty thresholds and the Federal poverty guidelines for 1988.[9]

Table A-1.—SELECTED POVERTY MEASURES FOR FAMILIES, 1987 AND 1988

	1987 Bureau of Census Thresholds	1988 HHS Poverty Guidelines		
		States [1]	Alaska	Hawaii
One person	[2] $5,776	$5,770	$7,210	$6,650
Two persons	[3] 7,399	7,730	9,660	8,900
Three persons	9,056	9,690	12,110	11,150
Four persons	11,612	11,650	14,560	13,400
Five persons	13,743	13,610	17,010	15,650
Six persons	15,534	15,570	19,460	17,900
Seven persons	17,672	17,530	21,910	20,150
Eight persons	19,478	19,490	24,360	22,400
Nine persons or more	23,319	+1,960	+2,450	+2,250

[1] Poverty guidelines in effect for 48 continental States and the District of Columbia.

[2] This is a weighted average. For a householder 15 to 64 years ofage the poverty threshold is $5,909; for those householders 65 years and older the poverty threshold is $5,447.

[3] This is a weighted average. For a two person family in which the head of the household is 15 to 64 years of age the poverty threshold is 7,641; for two person households in which the head of household is 65 years or older the poverty threshold is $6,872.

Source: Unpublished Bureau of the Census data and Federal Register, vol. 53, no. 29, February 12, 1988, p. 4214.

B. The Incidence of Poverty—1986

In 1986, an estimated 13.6 percent of the population (32.4 million persons) had incomes below the poverty threshold. However, the incidence of poverty varied among different demographic groups. For example, children are more likely to be poor than other age groups. The poverty rate for children under 18 in 1986 was 20.4 percent, the rate for working age adults (individuals between 18 and 64 years of age) was 10.9 percent, and the rate for the aged (individuals 65+) was 12.4 percent. The poverty rate also varied by race and ethnicity. The rate of poverty for blacks was 31.1 percent, that for Hispanics was 27.3 percent, and that for whites was 11.0 percent. The poverty rate for individuals in single parent female-headed families was 34 percent, the rate for other families was 8 percent. Figure A–2 provides a comparison of these poverty rates for selected demographic group.[10]

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[7] Some federally funded health programs that use this guideline include the Maternal and Child Health Services block grants, Community Health Centers, and Migrant Health Centers. For a detailed description of the programs that used these guidelines see U.S. Library of Congress. Congressional Research Service. Cash and Noncash Benefits for Persons with Limited Incomes: Eligibility Rules, Recipient and Expenditure Data, fiscal year 1983-86. CRS Report for Congress No. 87-759 EPW, by Vee Burke. Washington, updated Sept. 10, 1987.

[8] The Federal poverty guidelines are a variant of the Census Bureau thresholds. The Census bureau thresholds are revised by: 1) rounding the dollar amounts off, 2) standardizing the dollar difference between different family sizes; 3) creating individual poverty guidelines for families greater than nine; and 4) creating separate guidelines for Alaska and Hawaii. This procedure was developed by the Community Services Administration (CSA) and approved by the Office of Management and Budget (OMB). Since the Omnibus Budget Reconciliation Act of 1981 (OBRA81), Public Law 97-35, which abolished CSA, the guidelines have been updated by DHHS.

[9] The Census Bureau poverty thresholds for 1988 were not available at the time this appendix was prepared.

1. POVERTY AND THE AGED

The 1986 aged poverty rate was the lowest rate ever measured for this group. The 1986 rate was almost one-third the 1959 rate, the first available year of poverty data for this group. There are a number of factors associated with this dramatic trend. First, there has been a substantial expansion of social security benefits. The program's expansion has occurred in two ways: 1) with an increase in the number of individuals receiving the benefits, and 2) with higher real benefits awarded. The number of retired workers, dependents of retired workers, and their survivors receiving social security has grown since the early sixties. Wage growth in the overall economy has resulted in increased initial benefits for social security recipients. In addition, ad hoc benefit increases occurred during the sixties and seventies; and since 1975, cost of living adjustments (COLAs) have protected these benefits against price inflation. Additional income support for the aged has occurred with the expansion of private pension programs.

2. POVERTY AND CHILDREN

In 1986, almost one out of every five children lived in a family with annual income below the poverty threshold. This high overall poverty rate for children is a continuation of a long term trend (see figure A–3). Since 1974, the poverty rate for children under 18 has been the highest of any age group. Two factors are related to this long term trend.

First, the overall child poverty rate has been influenced by a secular trend. There has been an almost continuous increase in the number of children living in single parent, female-headed families. From 1959 to 1986, the share of children living in female-headed families increased from about 10 to 21 percent. The poverty rate for children in these single parent families historically has been very high. For example, in 1959, the poverty rate for children in female-headed families was 72.2 percent. Since 1959, the poverty rate for this group of children has dropped, but it still equalled 54.4 percent in 1986, a rate four times as high as the overall rate.

The second factor influencing the child poverty rate is more cyclical in nature, the fluctuations in the poverty rate for two parent

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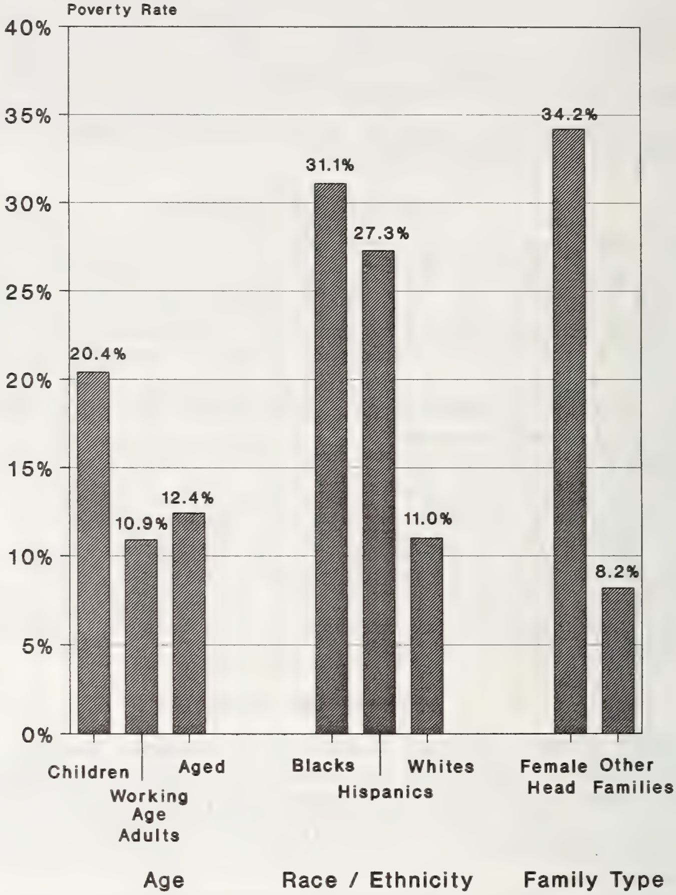
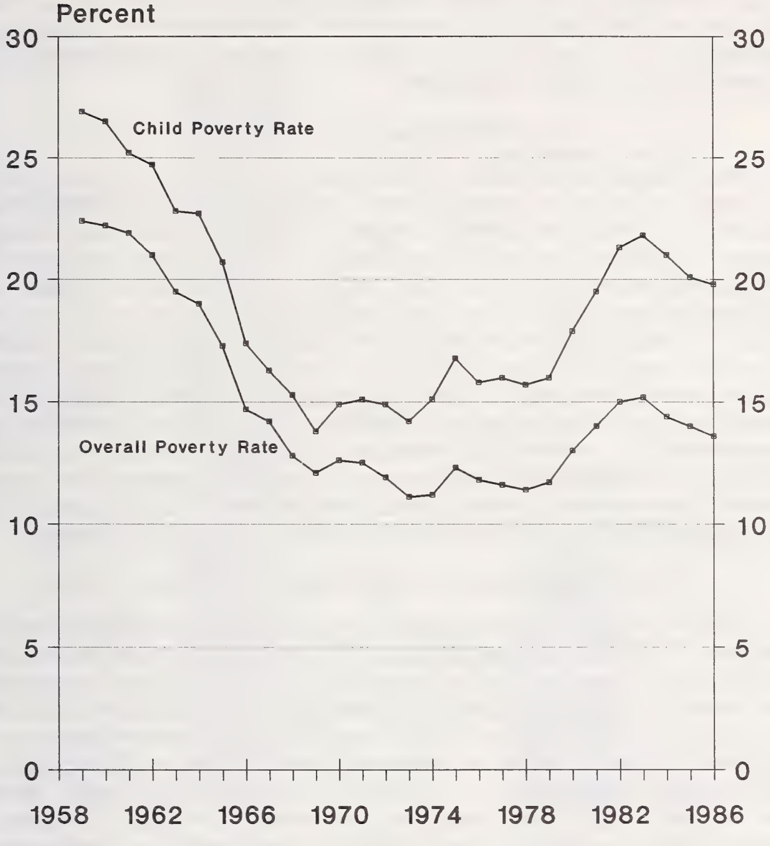
[10] A more detailed discussion of poverty, can be found in U.S. Library of Congress. Congressional Research Service. Progress against Poverty in the United States (1959 to 1986). CRS Report for Congress No. 87–85 EPW, by Thomas Gabe. Washington, Sept. 2, 1987.

Figure A-2
Incidence of Poverty in Selected Groups, 1986



Source: March 1987 Current Population Survey

Figure A-3
A Comparison of the Overall Poverty Rate and the Poverty Rate for Children



Source: U.S. Bureau of the Census, Current Population Reports, Series P-60, Nos. 130 and 157.

families. The poverty rate for children in two parent families is substantially lower than the rate for children in single parent female-headed families. In 1986, children in two parent families had a poverty rate of 10.8 percent. But the rate for these families is much more sensitive to fluctuations in the economy. A large share of the increase in the child poverty from 1979 to 1983 was a result of an increase in the poverty rates for children in two parent families. Since 1983, the child poverty rate for two parent families has declined by 20 percent; this helped in reducing the overall child poverty rate by about 9 percent.

3. POVERTY, RACE AND ETHNICITY

Even though a majority of the poor are white (68 percent), the incidence of poverty among blacks and Hispanics is considerably higher. In 1986, the poverty rates for blacks (31.1) was almost 3 times as high as the rate for whites (11.0), the poverty rate for Hispanics was more than 2.5 times as high (27.3 percent). While both of these groups suffer from relatively high poverty rates, the reasons for their high rates vary. For blacks, an important factor in this high poverty rate is the large number of children living in single-parent families. In 1986, 51 percent of black children lived in female-headed single parent families; the poverty rate for this group was 67.1 percent. In contrast, Hispanic poverty is not dominated by individuals in single-parent families. Factors like low educational attainment, recent immigration and larger families are likely contributing factors to their high incidence of poverty.[11]

C. The Composition of the Poor Population—1986

Another perspective on poverty is gained by examining the composition of the poverty population. Figure A–4 portrays what demographic groups make up the poor in 1986, taking into account age, and family type. A number of important characteristics of the poor can be seen in this figure. First, roughly 40 percent of the poor are children under 18; another major share of the poor (49 percent) are working age adults, and 11 percent of the poor are aged. Second, the composition of the poor also varies within each of these age groups. Sixty percent of poor children are found in single parent families.[12] Fifty-seven percent of working age poor adults are living in families with children, and 28 percent are not living with relatives. In contrast to children and working age adults, the largest share of the aged poor (66 percent) are not living in families.

Looking at the race and ethnicity of the poor, 68 percent of the poor are white, 28 percent are black, and 16 percent are of Hispanic origin.

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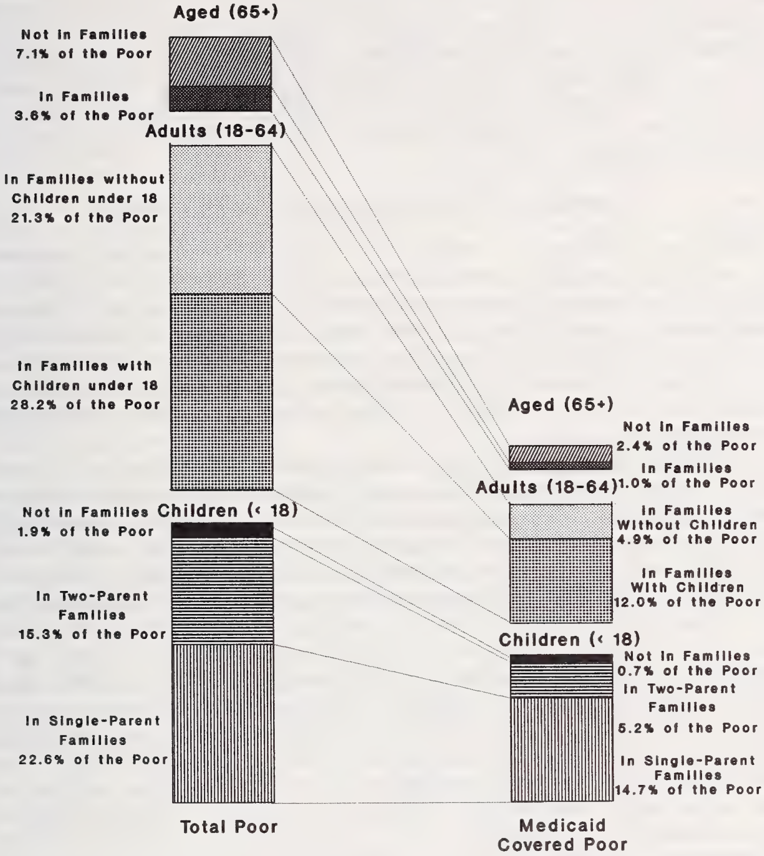
[11] See U.S. Library of Congress. Congressional Research Service. Hispanic Children in Poverty. CRS Report No. 85–170 EPW, by Vee Burke, Thomas Gabe, and Richard Rimkunas. Washington, Sept. 13, 1985.

[12] This estimate includes a very small number of children in single parent families headed by a male (roughly 2 percent of poor children). Children over 15 living with a spouse or living away from any relatives are excluded from this estimate.

Figure A-4
Composition of Total and Medicaid Poverty Populations, By Age and Family Structure 1986



Source: March 1987 CPS.

III. THE POOR, NEAR-POOR AND MEDICAID COVERAGE

As detailed in chapter II, there are a number of ways that an individual can become eligible for Medicaid. Most Medicaid beneficiaries are eligible because they meet categorical eligibility criteria. Generally, this means that they meet the income and other criteria to receive some form of cash assistance. This group of Medicaid beneficiaries is likely to have income below or near the poverty threshold. However, some individuals who do not meet the eligibility criteria for these cash assistance programs may still qualify for Medicaid under other rules+—either as a result of medical need or as a result of some of the other optional or mandatory State eligibility criteria. This group has total income that may exceed the poverty threshold.

A. Medicaid Coverage Rates of the Poor

Based on information contained in the CPS, about 41 percent of the poor (13.2 million) were covered by Medicaid during 1986. Another 26 percent of the poor (8.4 million) were covered by some other form of public or private health insurance, while roughly one-third of the poor (10.8 million) reported having no health insurance at all.[13] Table A–2 provides a percentage distribution of health insurance coverage for the poor by selected demographic characteristics.

The Medicaid program has attempted to help persons in need by limiting the individual's financial burdens associated with basic medical services. The program performs this role by making payments on behalf of those in need for basic medical services. One way Medicaid performs this function is by providing payments for medical services for those who otherwise would not have any insurance coverage, although having medical insurance is not a bar to Medicaid eligibility. Table A–2 highlights Medicaid's role as the sole payor of medical services for the nonaged poor. In 1986, 38 percent of the nonaged poor relied on Medicaid as their only source of health insurance. Since Medicare provides almost universal coverage of the aged, Medicaid is not likely to be the sole payor of most medical services for the aged poor. In the CPS sample, all the aged poor who were covered by Medicaid sometime during 1986 were also covered by Medicare.

Roughly 52 percent of poor children under 18 are covered by Medicaid, this is the highest coverage rate of any age group. About 34 percent of poor working age adults are covered by Medicaid, while 31 percent of the aged poor are covered.[14]

Medicaid's link to the cash assistance programs results in relatively high coverage rates for children living in single parent families, and adults living in families with children. Poor working age adults and their children are likely to receive Medicaid through AFDC eligibility.

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[13] Estimates are for those individuals who were covered by Medicaid at some point in 1986. Individuals covered by Medicaid may have also been covered by another type of health insurance during the year.

[14] It should be noted that the CPS does not sample individuals in institutions, since a sizable portion of the aged Medicaid population are in long term care institutions (see appendix C) this percentage rate for Medicaid coverage of the aged poor should be viewed with some caution.

Sixty-four percent of the poor in single-parent families with children (the principal recipients of AFDC) are covered by Medicaid. They are covered at a rate that is about 2.5 times the coverage rate of the poor in two parent families with children (26 percent).

Not all of the poor in families with children qualify for Medicaid. For example, the standard definition of AFDC assistance units (and automatic Medicaid eligibility) limits cash welfare payments to the parent(s) and all related children under 18 (or at State option 19). Generally, other individuals in these families, like older siblings, aunts, uncles, and grandparents would not be eligible.[15]

Forty-one percent of poor children over 18 or other relatives living in these families with children are covered by Medicaid. These individuals may either receive Medicaid because of State optional coverage of the categorically needy (e.g., extending the age limit for dependent children to those older than 18) or because these persons qualify for Medicaid on their own (e.g., grandparents who are eligible for SSI).

Figure A–4 provides additional detail on the demographic composition of the poor covered by Medicaid. Most poor children covered by Medicaid live in single parent families (72 percent). Seventy-one percent of all working age adults covered by Medicaid are in families with children. Seven out of ten aged poor persons covered by Medicaid are not living with a relative.

Medicaid coverage rates for racial-ethnic groups are partly influenced by the share of two-parent and single-parent families with incomes below poverty that make up these demographic groups. Fifty-three percent of poor blacks are covered by Medicaid; 43 percent of poor Hispanics; and 34 percent of poor whites (see table A–2). Single-parent black families represent almost 80 percent of poor black families; for Hispanics and whites the comparable figures are 50 and 40 percent.

Table A–2.—SHARE OF THE POOR WITH MEDICAL COVERAGE, OTHER HEALTH INSURANCE COVERAGE, OR NO HEALTH INSURANCE COVERAGE BY AGE AND FAMILY TYPE, 1986

	Covered by Medicaid			Other insurance only	No health insurance	Total
	Medicaid only	Medicaid and other insurance	Total			
NUMBER OF INDIVIDUALS (IN THOUSANDS)						
Age:						
Under 18	6,174	502	6,676	1,973	4,227	12,876
18 to 64	4,744	722	5,466	4,075	6,476	16,017
65 and over	0	1,090	1,090	2,310	77	3,477
Family type:						
Families with related children under 18:						
Single parent	6,536	468	7,004	1,079	2,697	10,780
Two parent	2,354	494	2,848	2,716	3,479	9,043
Children 18 and over and others	807	108	915	304	1,070	2,228
Families without related children under 18:						
In families	428	324	752	1,484	1,176	3,412
Single individuals	793	919	1,712	2,774	2,360	6,846

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[15] Despite this definition of the AFDC unit, some States extend Medicaid eligibility to related children between the ages of 18 and 21. See chapter II for more information.

Table A–2.—SHARE OF THE POOR WITH MEDICAL COVERAGE, OTHER HEALTH INSURANCE COVERAGE, OR NO HEALTH INSURANCE COVERAGE BY AGE AND FAMILY TYPE, 1986—Continued

	Covered by Medicaid			Other insurance only	No health insurance	Total
	Medicaid only	Medicaid and other insurance	Total			
Race ethnicity:						
White (non-Hispanic)	4,494	1,343	5,837	5,979	5,427	17,244
Black (non-Hispanic)	4,057	639	4,697	1,370	2,770	8,837
Hispanic	1,954	224	2,178	760	2,179	5,117
Other (non-Hispanic)	413	107	520	248	404	1,173
Total	10,918	2,314	13,232	8,357	10,781	32,370
DISTRIBUTION (IN PERCENT)						
Age:						
Under 18	47.9	3.9	51.8	15.3	32.8	100
18 to 64	29.4	4.6	34.1	26.2	39.8	100
65 and over	0.0	31.3	31.3	66.4	2.2	100
Family type:						
Families with related children under 18:						
Single parent	60.6	4.3	64.9	10.0	25.0	100
Two parent	26.0	5.5	31.5	30.0	38.5	100
Children 18 and over and others	35.3	4.7	40.0	13.3	46.7	100.0
Families without related children under 18:						
In families	12.5	9.5	22.0	43.5	34.5	100
Single individuals	11.6	13.4	25.0	40.5	34.5	100
Race ethnicity:						
White (non-Hispanic)	26.1	7.8	33.8	34.6	31.5	100.0
Black (non-Hispanic)	45.9	7.2	53.2	15.5	31.3	100
Hispanic	38.2	4.4	42.6	14.8	42.6	100
Other (non-Hispanic)	35.2	9.1	44.3	21.1	34.4	100
Total	33.7	7.1	40.9	25.8	33.3	100

Note: Estimates of insurance coverage for families with related children are for parents and related children in these families, all other family members are found in the category "children 18 and over and others". Poverty Status of an individual is based on total family income. The CPS does not ask questions about dual health insurance coverage. Individuals responding that they were covered by more than one form of health insurance in 1986, may either have had dual coverage, or different forms of insurance at different times of the year. The "Other insurance only" category includes Medicare, and Champus as well as private health insurance coverage.

Source: March 1987 Current Population Survey. All numbers are estimates prepared by Education and Public Welfare Division, Congressional Research Service.

B. Factors Associated with Medicaid Coverage of the Poor

There are a number of different factors related to the coverage of the poor by Medicaid. First, the categorically needy eligibility criteria for Medicaid limit program coverage to certain types of individuals. For example, in the AFDC program two criteria in addition to the explicit income test include the dependency criteria and the resource criteria. In order to receive AFDC payments a needy child and its mother or caretaker must be deprived of support because the child's father is absent from home, is unable to work or is deceased, or in some States because the principal earner is unemployed (AFDC–UP families). The resource criteria set a level for the amount of assets a family can have and still be eligible for AFDC.[16]

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[16] See chapter II for details on these criteria.

The AFDC dependency criteria eliminate a number of individuals from Medicaid categorical eligibility regardless of their income level. Nonaged singles and childless couples generally are not eligible for Medicaid as a result of this criterion.

Under SSI, an individual must meet the definition of "need" by being aged, blind or disabled as well as having income below the maximum allowable levels. Like the AFDC program, the SSI program also has asset limits.

Second, the statistical measure of poverty is not equivalent to the maximum allowable income amounts associated with the categorical eligibility criteria of Medicaid. The maximum level for a family's income that is allowable before the family is no longer eligible for AFDC or SSI, and categorically eligible for Medicaid varies from State to State, by family size, and whether a member of the family is working. Depending on all of these factors, the maximum allowable income for a family can fall above or below Federal poverty guidelines. The maximum allowable income for individuals receiving SSI is less likely to vary from State to State, but these income limits do vary, depending on whether the State provides supplementary SSI payments, whether an SSI recipient lives alone or with a spouse, and whether the recipient has any earned income.

Finally, while some poor people become eligible for Medicaid as a result of the receipt of cash assistance payments, some qualify because they are medically needy. In these cases, the individual's gross income is not directly related to their Medicaid eligibility. Rather, these individuals qualify for Medicaid because their medical expenses are so high that their net income (i.e., income after medical expenses) is below the State's maximum allowable income for medically needy beneficiaries of Medicaid. While the effective maximum allowable net income for these individuals is below the poverty guidelines in most States, a family's gross income can exceed the categorical eligibility income limits associated with the cash assistance programs and the poverty threshold.

1. AFDC ELIGIBILITY, CATEGORICALLY NEEDY INCOME LIMITS AND POVERTY [17]

Definitions of need, payment levels, resource and income limits for the AFDC program vary from State to State. The maximum allowable income associated with AFDC eligibility and recipiency is based on a State's "need standard" and "payment standard." States define a monthly needs standard; this is the income amount that the individual State decides is necessary for purchasing such items as food, clothing, shelter, household supplies and personal care items. Actual AFDC payment amounts are based on the State's payment standard and a family's countable income. The State's payment standard can be equal to or less than the needs standard.

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[17] A detailed discussion of AFDC eligibility and payment levels can be found in U.S. Library of Congress. Congressional Research Service. Aid to Families with Dependent Children (AFDC): Need Standards, Payment Standards, and Maximum Benefits for Families with No Countable Income. CRS Report for Congress No 87-799, by Carmen Solomon. Washington, Sept. 28, 1987.

In order to be eligible for AFDC payments and automatically eligible for Medicaid, a family must pass two income tests: 1) a gross income test, and 2) a countable income test:

—*gross income test.* The gross income test compares a family's gross income to the State's needs standard. An AFDC applicant's or recipient's gross monthly income can not exceed 185 percent of the State's needs standard.

—*countable income test.* An applicant's countable income must be less than the State's need standard. An AFDC recipient's countable income must be less than the State's payment standard.

The AFDC program provides incentives for labor force participation of its recipients by using a different definition of countable income for its recipients than the definition used in determining program eligibility. An applicant's countable income is defined as gross income minus child care costs up to $160 per child, and a standard allowance of $75 a month. For a recipient the income disregards used in the countable income definition are larger; recipients are entitled to an additional income disregard, the work incentive bonus. Like the AFDC applicant, an AFDC recipient is allowed to deduct child care costs, and the $75 standard allowance. But in addition, during the first year on a job, a work incentive bonus is allowed. This bonus varies based on the length of employment. During the first 4 months of a job the bonus is equivalent to the first $30 of earned income plus one-third of additional earnings after the child care and standard deductions are taken. For the remaining 8 months the bonus is equivalent to $30. After 12 months there is no longer a work incentive bonus. Since these work disregards vary by the length of employment, an AFDC recipient's maximum allowable income will also vary depending on how long he or she has worked.

As a result of these complex set of rules, the maximum allowable income levels used to determine Medicaid eligibility vary by State, by family size, and by the length of time employed. Table A–3 illustrates this point; it shows the State by State variation in the maximum allowable income amounts for a family of three. The table provides estimates of the maximum allowable amounts under three circumstances:

—when a family has no other income beside its AFDC payment (the maximum AFDC payment amount);

—the maximum allowable income during the first 4 months of employment (this allows a $30 and one-third earned income disregard, and a $75 standard deduction); and

—the maximum allowable income after 12 months of employment (allowing for the $75 standard deduction).[18]

Families relying on AFDC payments as their source of income will have income levels below the poverty guidelines in all 50 States. Families with a member in their first 4 months of employment, depending on the State they reside in, can have income ranging from 35 percent of poverty to 142 percent of poverty. Fourteen States allow combined AFDC payments and earned income to exceed the poverty guidelines for these first 4 months of employment. The maximum allowable income after 12 months of employment falls between these two extremes, ranging between 24 percent and 95 percent of poverty.

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[18] The maximum allowable income during the 5th to 12th month of employment is equal to this amount plus $30.

Table A–3.—AFDC MAXIMUM ALLOWABLE INCOME LIMITS FOR A FAMILY OF THREE, JANUARY 1988

State	Maximum AFDC Benefits		Maximum Income Using Standard Deduction (after 12 months of employment)		Maximum Income with Work Disregards in Effect (first 4 months of employment)	
	Monthly Income	Percent of Poverty Guideline [1]	Monthly Income [2]	Percent of Poverty Guideline	Monthly Income [3]	Percent of Poverty Guideline
Alabama	$118	14.61	$193	23.90	$282	34.92
Alaska	779	77.19	854	84.62	1,274	126.24
Arizona [5]	293	36.28	368	45.57	545	67.49
Arkansas	202	25.02	277	34.30	408	50.53
California	633	78.39	708	87.68	1,055	130.65
Colorado	356	44.09	496	61.42	737	91.27
Connecticut	601	74.43	676	83.72	1,007	124.71
Delaware	319	39.50	394	48.79	584	72.32
District of Columbia	379	46.93	454	56.22	674	83.47
Florida	275	34.06	350	43.34	518	64.15
Georgia	263	32.57	441	54.61	654	80.99
Hawaii	515	55.43	590	63.50	878	94.49
Idaho	304	37.65	379	46.93	561	69.47
Illinois	342	42.35	417	51.64	618	76.53
Indiana	288	35.67	363	44.95	537	66.50
Iowa	381	47.18	456	56.47	677	83.84
Kansas	409	50.65	484	59.94	719	89.04
Kentucky	207	25.63	282	34.92	383	47.43
Louisiana	190	23.53	265	32.82	[4] 390	[4] 48.30
Maine	416	51.52	648	80.25	965	119.50
Maryland	359	44.46	434	53.75	644	79.75
Massachusetts	510	63.16	585	72.45	870	107.74
Michigan (Wayne Co.)	528	65.39	603	74.67	897	111.08
Minnesota	532	65.88	607	75.17	903	111.83
Mississippi	120	14.86	443	54.86	657	81.36
Missouri	282	34.92	357	44.21	528	65.39
Montana	359	44.46	434	53.75	644	79.75
Nebraska	350	43.34	425	52.63	630	78.02
Nevada	325	40.25	400	49.54	593	73.44
New Hampshire	486	60.19	561	69.47	834	103.28
New Jersey	424	52.51	499	61.80	741	91.76
New Mexico	264	32.69	339	41.98	488	60.43
New York (New York City)	539	66.75	614	76.04	[4] 914	[4] 113.19
North Carolina	266	32.94	341	42.23	504	62.41
North Dakota	371	45.94	446	55.23	662	81.98
Ohio	309	38.27	384	47.55	569	70.46
Oklahoma	310	38.39	385	47.68	570	70.59
Oregon	412	51.02	487	60.31	723	89.54
Pennsylvania	402	49.78	477	59.07	708	87.68
Rhode Island	503	62.29	578	71.58	860	106.50
South Carolina	200	24.77	463	57.34	687	85.08
South Dakota	366	45.33	441	54.61	654	80.99
Tennessee	159	19.69	428	53.00	635	78.64
Texas	184	22.79	259	32.07	381	47.18
Utah	376	46.56	768	95.11	1,145	141.80

Table A-3.—AFDC MAXIMUM ALLOWABLE INCOME LIMITS FOR A FAMILY OF THREE, JANUARY 1988—Continued

State	Maximum AFDC Benefits		Maximum Income Using Standard Deduction (after 12 months of employment)		Maximum Income with Work Disregards in Effect (first 4 months of employment)	
	Monthly Income	Percent of Poverty Guideline [1]	Monthly Income [2]	Percent of Poverty Guideline	Monthly Income [3]	Percent of Poverty Guideline
Vermont	603	74.67	678	83.96	1,010	125.08
Virginia	354	43.84	429	53.13	636	78.76
Washington	492	60.93	567	70.22	843	104.40
West Virginia	249	30.84	324	40.12	479	59.32
Wisconsin	517	64.02	592	73.31	881	109.10
Wyoming	360	44.58	435	53.87	645	79.88

	Maximum AFDC Benefit		Maximum Income Using Standard Deduction (after 12 months of employment)		Maximum Income with Work Disregards in Effect (first 4 months of employment)	
	Number	Percent	Number	Percent	Number	Percent
Jurisdictions with:						
Maximum Income less than 50 percent of Poverty Guideline	34	66.7	17	33.3	4	7.8
Maximum Income between 50 and 75 percent of Poverty Guideline	15	29.4	26	51.0	13	25.5
Maximum Income between 75 and 100 percent of Poverty Guideline	2	3.9	8	15.7	20	39.2
Maximum Income greater than Poverty Guideline	0	0.0	0	0.0	14	27.5

[1] Percentage figure based on annual 1988 Federal poverty guidelines for a family of three, $9,690 in the forty eight contiguous States.

[2] Assumes that family is taking the $75 standard deduction. For months 5 to 12 of employment, the maximum allowable monthly income equals this amount plus $30.

[3] Assumes that the family is taking the $75 standard deduction, in addition, the first $30 of earned income and one-third of the remaining earned income is disregarded.

[4] Allowable monthly maximum income amount equals the gross income limit of 185 percent of the State's need standard.

[5] Arizona provides Medicaid coverage under a waiver option. These income levels are for illustrative purposes only.

Source: Education and Public Welfare Division. Congressional Research Service.

Figure A–5 portrays this information as a percent of the Federal poverty guidelines for a family of three in January of 1988.

Generally, when a family has no countable income its AFDC payment represents its total income.[19] This income level corresponds to the maximum AFDC payment amount. These income levels are portrayed as the dotted bars in figure A–5. Families of three depending solely on AFDC payments as their total family income, will have incomes that range from 15.2 to 80.4 percent of poverty. If a family's income from sources other than AFDC exceeds these levels, individuals in the family can lose their AFDC eligibility and in turn their automatic Medicaid eligibility.[20]

Since the AFDC program disregards some child and spousal support income and in certain circumstances, some earned income, families can have total incomes that exceed these maximum pay-

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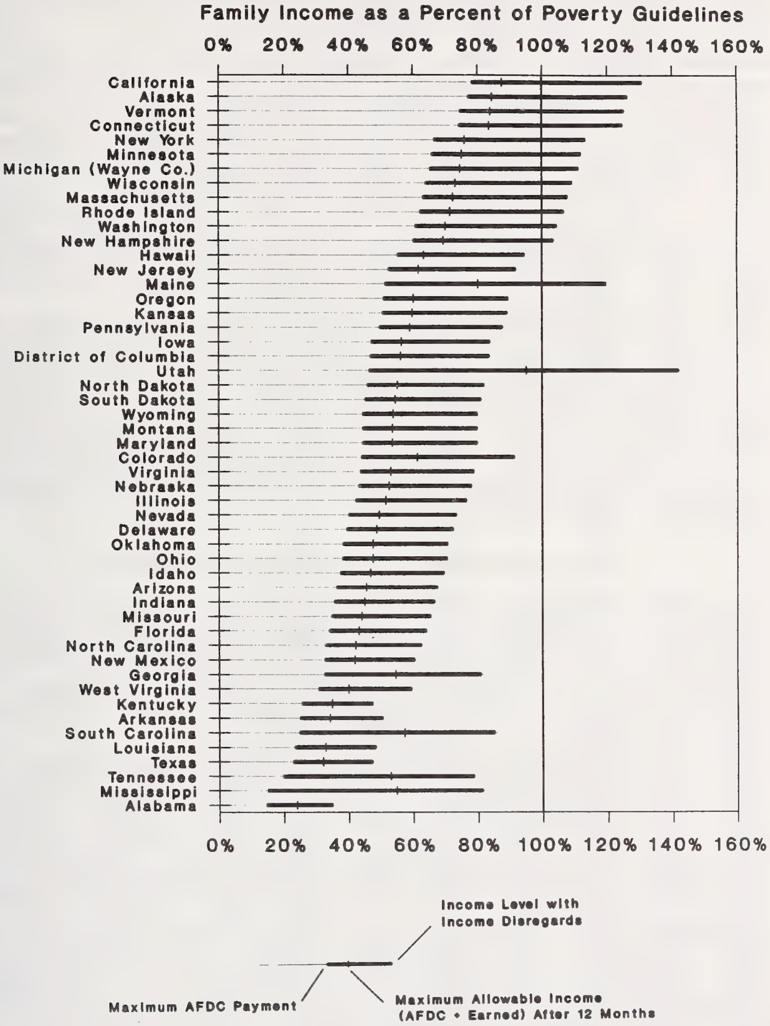
[19] Since countable income does allow for some deductions for child support payments and work expenses, a family's actual gross income can exceed the AFDC payment.

[20] There are some important exceptions to this general rule. If a family loses AFDC coverage because of employment, or the receipt of child or spousal support Medicaid coverage must be continued for 4 months. In addition, States must extend Medicaid coverage for 9 months to families losing AFDC eligibility because they no longer qualify for the earned income disregards. States have the option to extend this coverage for an additional 6 months. See chapter II on eligibility for additional details on these exceptions.

Figure A-5
Maximum Income Limits for a Family of Three Receiving AFDC, as a Share of Federal Poverty Guidelines, January 1988



Source: See table A-3.

ment amounts but still qualify for AFDC and Medicaid. The solid line on the figure represents the level of income where work-related income disregards are in effect in each State. The upper-most point on the solid bar represents the maximum allowable gross income amount for a family of three that continues to receive AFDC payments and Medicaid coverage during the first 4 months of employment. The figure assumes the family has no child care expenses, takes a standard deduction of $75 per month, and takes the $30 and one-third of earned income disregarded under AFDC program rules. After 4 months of work this maximum allowable income amount no longer allows for one-third of a family's earned income to be disregarded. The result is a lower maximum allowable income amount.[21] After 12 months of employment the $30 deduction is also eliminated and the monthly maximum allowable income falls again. The maximum allowable income after 12 months of employment is depicted as the hash marks in figure A-5. This hash mark also indicates the maximum allowable income level when the family has no earned income.

This brief discussion of maximum allowable income levels associated with AFDC receipt indicates that categorical eligibility income standards alone can not guarantee universal Medicaid coverage for poor families with children. Even when the most liberal work disregards are in effect, during the first 4 months of employment, families with incomes below the Federal poverty guidelines may not qualify for AFDC payments and not be categorically eligible for Medicaid in some States.

2. SSI AND MEDICAID CATEGORICAL ELIGIBILITY

The SSI program provides monthly cash payments to the low income blind, disabled and aged. These cash assistance payments consist of a basic Federal payment plus in some States, a State supplemental amount. Most States provide Medicaid coverage to recipients of Federal SSI payments. However, States do have the option of using more restrictive eligibility rules.[22]

In order to qualify for Federal SSI benefits an individual must meet program eligibility criteria about blindness, age, or disability and have countable income less than the maximum allowable income limits provided in table A-4. The regular Federal SSI benefit guarantees a minimum income to all SSI recipients, at its option a State can supplement this Federal benefit. In 1988, the result of the regular Federal benefit is that the maximum allowable income levels associated with Medicaid eligibility for SSI beneficiaries never falls below 74 percent of the Federal poverty guidelines for an individual. For many States these income levels measured as a share of the poverty threshold are higher than those in the AFDC program. State supplements can increase this level. For example, California's State supplement raises an individual's income to 125 percent of the poverty guideline. Like the AFDC program, the SSI program disregards some earned income. This earned income disregard results in maximum allowable income amounts for working SSI recipients, generally the disabled, exceeding the poverty guideline in all States.

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[21] Under Medicaid eligibility rules, families that lose AFDC coverage because they no longer qualify for the $30 and one-third work disregard must be covered by Medicaid for another 9 months.

[22] Fourteen States uses more restrictive rules, see chapter II for a list of these States, and chapter V for a discussion of how these eligibility rules are administered.

Table A–4.—SSI MAXIMUM ALLOWABLE INCOME LIMITS FOR INDIVIDUALS AND COUPLES, JANUARY 1988

State	Individual				Couple			
	SSI Income (Maximum Benefit)		With Earned Income		SSI Income (Maximum Benefit)		With Earned Income	
	Monthly Income [1]	Percent of Poverty Guideline [2]	Monthly Income [3]	Percent of Poverty Guideline [2]	Monthly Income [1]	Percent of Poverty Guideline [2]	Monthly Income [3]	Percent of Poverty Guideline [2]
Alabama	$354	73.62	$793	164.92	$532	82.59	$1,149	178.37
Alaska	659	109.68	1,403	233.51	976	121.24	2,037	253.04
Arkansas	354	73.62	793	164.92	532	82.59	1,149	178.37
California	575	119.58	1,235	256.85	1,066	165.49	2,217	344.17
Colorado	412	85.68	909	189.05	648	100.60	1,381	214.39
Connecticut [4]	747	155.36	1,579	328.39	1134	176.04	2,353	365.28
Delaware	354	73.62	793	164.92	532	82.59	1,149	178.37
District of Columbia	369	76.74	823	171.16	562	87.24	1,209	187.68
Florida	354	73.62	793	164.92	532	82.59	1,149	178.37
Georgia	354	73.62	793	164.92	532	82.59	1,149	178.37
Hawaii [4]	359	64.78	803	144.90	541	72.94	1,167	157.35
Idaho	427	88.80	939	195.29	576	89.42	1,237	192.03
Illinois [4]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Indiana [4]	354	73.62	793	164.92	532	82.59	1,149	178.37
Iowa	354	73.62	793	164.92	532	82.59	1,149	178.37
Kansas	354	73.62	793	164.92	532	82.59	1,149	178.37
Kentucky	354	73.62	793	164.92	532	82.59	1,149	178.37
Louisiana	354	73.62	793	164.92	532	82.59	1,149	178.37
Maine	364	75.70	813	169.08	547	84.92	1,179	183.03
Maryland	354	73.62	793	164.92	532	82.59	1,149	178.37
Massachusetts	483	100.45	1,051	218.58	734	113.95	1,553	241.09
Michigan (Wayne Co.)	384	79.86	853	177.40	577	89.57	1,239	192.34
Minnesota [4]	389	80.90	863	179.48	598	92.83	1,281	198.86
Mississippi	354	73.62	793	164.92	532	82.59	1,149	178.37
Missouri [4]	354	73.62	793	164.92	532	82.59	1,149	178.37
Montana	354	73.62	793	164.92	532	82.59	1,149	178.37
Nebraska [4]	397	82.56	879	182.81	598	92.83	1,281	198.86
Nevada	390	81.11	865	179.90	606	94.08	1,297	201.35
New Hampshire [4]	381	79.24	847	176.15	553	85.85	1,191	184.89
New Jersey	385	80.07	855	177.82	557	86.47	1,199	186.13
New Mexico	354	73.62	793	164.92	532	82.59	1,149	178.37
New York (New York City)	426	88.60	937	194.87	625	97.02	1,335	207.24
North Carolina [4]	354	73.62	793	164.92	532	82.59	1,149	178.37
North Dakota [4]	354	73.62	793	164.92	532	82.59	1,149	178.37
Ohio [4]	354	73.62	793	164.92	532	82.59	1,149	178.37
Oklahoma [4]	418	86.93	921	191.54	660	102.46	1,405	218.11
Oregon	356	74.04	797	165.75	532	82.59	1,149	178.37
Pennsylvania	386	80.28	857	178.23	581	90.19	1,247	193.58
Rhode Island	413	85.89	911	189.46	643	99.82	1,371	212.83
South Carolina	354	73.62	793	164.92	532	82.59	1,149	178.37
South Dakota	369	76.74	823	171.16	547	84.92	1,179	183.03
Tennessee	354	73.62	793	164.92	532	82.59	1,149	178.37
Texas	354	73.62	793	164.92	532	82.59	1,149	178.37
Utah [4]	363	75.49	811	168.67	550	85.38	1,185	183.96

Table A-4.—SSI MAXIMUM ALLOWABLE INCOME LIMITS FOR INDIVIDUALS AND COUPLES, JANUARY 1988—Continued

State	Individual				Couple			
	SSI Income (Maximum Benefit)		With Earned Income		SSI Income (Maximum Benefit)		With Earned Income	
	Monthly Income [1]	Percent of Poverty Guideline [2]	Monthly Income [3]	Percent of Poverty Guideline [2]	Monthly Income [1]	Percent of Poverty Guideline [2]	Monthly Income [3]	Percent of Poverty Guideline [2]
Vermont	412	85.68	909	189.05	638	99.04	1,361	211.28
Virginia [4]	354	73.62	793	164.92	532	82.59	1,149	178.37
Washington	382	79.45	849	176.57	554	86.00	1,193	185.20
West Virginia	354	73.62	793	164.92	532	82.59	1,149	178.37
Wisconsin	457	95.04	999	207.76	698	108.36	1,481	229.91
Wyoming	374	77.78	833	173.24	572	88.80	1,229	190.79

	Individual				Couple			
	SSI Income (Maximum Benefit)		With Earned Income		SSI Income (Maximum Benefit)		With Earned Income	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Jurisdictions with:								
Maximum Income less than 50 percent of Poverty Guideline	0	0.0	0	0.0	0	0.0	0	0.0
Maximum income between 50 and 75 percent of Poverty Guideline	26	51.0	0	0.0	1	2.0	0	0.0
Maximum income between 75 and 100 percent of Poverty Guideline	20	39.2	0	0.0	42	82.4	0	0.0
Maximum income greater than Poverty Guideline	4	7.8	50	98.0	7	13.7	50	98.0

[1] Monthly income estimate is maximum SSI benefit. Generally, SSI eligibility rules allow an additional $20 of monthly income.

[2] Percentage figures are based on the annual 1988 Federal poverty guidelines for an individual or couple.

[3] Monthly income estimate assumes that $20 monthly income disregard is in effect. In addition, the estimate assumes that the first $60 of earned income and one-half of remaining earned income is disregarded.

[4] SSI monthly maximum criteria is for illustrative purposes only. State uses a more restrictive eligibility criteria than the SSI standard to determine Medicaid eligibility. For additional details see Chapter II, Eligibility.

Note: Maximum allowable income is based on Federal SSI payments and any State supplemental payment amounts.

Source: All figures are Congressional Research Service estimates based on information from the Office of Research and Statistics, Social Security Administration, the Commerce Clearing House, and the National Governor's Association.

3. ELIGIBILITY FOR THE MEDICALLY NEEDY

Individuals with incomes greater than the income thresholds used in the AFDC or SSI program may still be eligible for Medicaid if they live in a State that provides coverage for the medically needy. These individuals must incur medical expenses that reduce their income to levels that are close to the thresholds used in the AFDC program for a family of comparable size. The medically needy income level can not exceed 133⅓ percent of the maximum AFDC payment amount for a family of the same size in the State. As of July 1987, the medically needy income eligibility threshold ranged from 28 to 109.7 percent of the Federal poverty guidelines (see table A–5). However, it should be remembered that the medically needy income thresholds are for income after medical expenses are deducted, and not gross income.

Table A–5.—MEDICAID MEDICALLY NEEDY ELIGIBILITY THRESHOLDS FOR A FAMILY OF THREE, AS A PERCENT OF POVERTY (AS OF JULY 1987)

	Maximum allowable net monthly income	Percent of poverty [1]
Arkansas	$275	35.5
California	850	109.7
Connecticut	625	80.6
District of Columbia	485	62.6
Florida	359	46.3
Georgia	350	45.2
Hawaii	491	55.1
Illinois	458	59.1
Iowa	508	65.5
Kansas	465	60.0
Kentucky	267	34.5
Louisiana	258	33.3
Maine	541	69.8
Maryland	417	53.8
Massachusetts	733	94.6
Michigan	537	69.3
Minnesota	709	91.5
Montana	404	52.1
Nebraska	450	58.1
New Hampshire	539	69.5
New Jersey	566	73.0
New York	617	79.6
North Carolina	350	45.2
North Dakota	435	56.1
Oklahoma	417	53.8
Oregon	549	70.8
Pennsylvania	425	54.8
Rhode Island	658	84.9
Tennessee	217	28.0
Texas	267	34.5
Utah	501	64.6
Vermont	617	79.6
Virginia	358	46.2
Washington	567	73.2
West Virginia	290	37.4
Wisconsin	689	88.9

[1] Based on 1987 Federal poverty guidelines for a family of three, $9,300 in the 48 States.

Note: States not listed do not provide for medically needy eligibility.
Source: National Governors' Association.

4. A COMPARISON OF MEDICAID ELIGIBILITY RULES

Medicaid's complex eligibility rules results in individuals facing differing maximum income levels in different eligibility categories. Generally, AFDC maximum income levels are lower than SSI levels for families of the same size. In addition, the medically needy "net income" levels in most States are lower than the SSI levels for families of the same size.[23]

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[23] Questions about whether an individual is treated unfairly because the medically needy and SSI income eligibility levels are different have been raised. In Hogan v. Schweiker (US S CT

Continued

Individuals qualifying under AFDC eligibility rules are often very different than those qualifying under the SSI rules. AFDC recipients are usually a female-headed single parent family with little or no earned income. SSI recipients are aged or disabled. In every State the maximum allowable income for AFDC is lower than the SSI level. Table A–6 provides a comparison of the income levels for an AFDC family of two and a couple under SSI.

Table A–6.—A COMPARISON OF SSI MAXIMUM ALLOWABLE INCOME LIMITS FOR A COUPLE WITH AFDC MAXIMUM ALLOWABLE INCOME LIMITS FOR A FAMILY OF TWO, JANUARY 1988

State	AFDC Family of Two						SSI Couple			
	Maximum AFDC Benefit		Maximum Income Using Standard Deduction (After 12 Months)		Maximum Income with All Work Disregards in Effect		SSI Income (maximum benefit)		With Earned Income	
	Monthly Income [1]	Percent of Poverty Guidelines [2]	Monthly Income [3]	Percent of Poverty Guidelines [2]	Monthly Income [4]	Percent of Poverty Guidelines [2]	Monthly Income [5]	Percent of Poverty Guidelines [2]	Monthly Income [6]	Percent of Poverty Guidelines [2]
Alabama	$88	13.7	$163	25.3	$237	36.8	$532	82.6	$1,149	178.4
Alaska	692	83.4	767	92.4	1,143	137.7	976	121.2	2,037	253.0
Arkansas	162	25.1	237	36.8	348	54.0	532	82.6	1,149	178.4
California	511	79.3	586	91.0	872	135.4	1,066	165.5	2,217	344.2
Colorado	280	43.5	406	63.0	602	93.5	648	100.6	1,381	214.4
Connecticut [7]	485	75.3	560	86.9	833	129.3	1,134	176.0	2,353	365.3
Delaware	236	36.6	311	48.3	437	67.8	532	82.6	1,149	178.4
District of Columbia	298	46.3	373	57.9	552	85.7	562	87.2	1,209	187.7
Florida	211	32.8	286	44.4	422	65.5	532	82.6	1,149	178.4
Georgia	220	34.2	381	59.1	564	87.6	532	82.6	1,149	178.4
Hawaii [7]	429	57.8	504	68.0	749	101.0	541	72.9	1,167	157.3
Idaho	245	38.0	320	49.7	473	73.4	576	89.4	1,237	192.0
Illinois [7]	250	38.8	325	50.5	480	74.5	n.a.	n.a.	n.a.	n.a.
Indiana [7]	229	35.5	304	47.2	449	69.7	532	82.6	1,149	178.4
Iowa	322	50.0	397	61.6	588	91.3	532	82.6	1,149	178.4
Kansas	338	52.5	413	64.1	612	95.0	532	82.6	1,149	178.4
Kentucky	179	27.8	254	39.4	331	51.4	532	82.6	1,149	178.4
Louisiana	138	21.4	213	33.1	312	48.4	532	82.6	1,149	178.4
Maine	310	48.1	502	77.9	746	115.8	547	84.9	1,179	183.0
Maryland	280	43.5	355	55.1	525	81.5	532	82.6	1,149	178.4
Massachusetts	422	65.5	497	77.2	738	114.6	734	113.9	1,553	241.1
Michigan (Wayne Co.)	474	73.6	549	85.2	816	126.7	577	89.6	1,239	192.3
Minnesota [7]	437	67.8	512	79.5	761	118.1	598	92.8	1,281	198.9
Mississippi	96	14.9	368	57.1	542	84.1	532	82.6	1,149	178.4
Missouri [7]	226	35.1	301	46.7	444	68.9	532	82.6	1,149	178.4
Montana	286	44.4	361	56.0	534	82.9	532	82.6	1,149	178.4
Nebraska [7]	280	43.5	355	55.1	518	80.4	598	92.8	1,281	198.9
Nevada	266	41.3	341	52.9	504	78.2	606	94.1	1,297	201.3
New Hampshire [7]	424	65.8	499	77.5	741	115.0	553	85.8	1,191	184.9
New Jersey	322	50.0	397	61.6	588	91.3	557	86.5	1,199	186.1
New Mexico	210	32.6	285	44.2	389	60.4	532	82.6	1,149	178.4
New York (New York City)	439	68.2	514	79.8	764	118.6	625	97.0	1,335	207.2
North Carolina [7]	231	35.9	306	47.5	452	70.2	532	82.6	1,149	178.4
North Dakota [7]	301	46.7	376	58.4	557	86.5	532	82.6	1,149	178.4

1982) 457 US 569, the court ruled that differing income eligibility levels in Massachusetts between the medically needy and SSI eligible did not violate the constitutional principle of equal treatment.

Table A-6.—A COMPARISON OF SSI MAXIMUM ALLOWABLE INCOME LIMITS FOR A COUPLE WITH AFDC MAXIMUM ALLOWABLE INCOME LIMITS FOR A FAMILY OF TWO, JANUARY 1988—Continued

State	AFDC Family of Two						SSI Couple			
	Maximum AFDC Benefit		Maximum Income Using Standard Deduction (After 12 Months)		Maximum Income with All Work Disregards in Effect		SSI Income (maximum benefit)		With Earned Income	
	Monthly Income [1]	Percent of Poverty Guidelines [2]	Monthly Income [3]	Percent of Poverty Guidelines [2]	Monthly Income [4]	Percent of Poverty Guidelines [2]	Monthly Income [5]	Percent of Poverty Guidelines [2]	Monthly Income [6]	Percent of Poverty Guidelines [2]
Ohio [7]	253	39.3	328	50.9	485	75.3	532	82.6	1,149	178.4
Oklahoma [7]	240	37.3	315	48.9	465	72.2	660	102.5	1,405	218.1
Oregon	352	54.6	427	66.3	633	98.3	532	82.6	1,149	178.4
Pennsylvania	315	48.9	390	60.5	578	89.7	581	90.2	1,247	193.6
Rhode Island	407	63.2	482	74.8	716	111.2	643	99.8	1,371	212.8
South Carolina	158	24.5	383	59.5	567	88.0	532	82.6	1,149	178.4
South Dakota	323	50.1	398	61.8	590	91.6	547	84.9	1,179	183.0
Tennessee	122	18.9	347	53.9	503	78.1	532	82.6	1,149	178.4
Texas	158	24.5	233	36.2	342	53.1	532	82.6	1,149	178.4
Utah [7]	301	46.7	631	98.0	939	145.8	550	85.4	1,185	184.0
Vermont	505	78.4	580	90.0	863	134.0	638	99.0	1,361	211.3
Virginia [7]	294	45.6	369	57.3	546	84.8	532	82.6	1,149	178.4
Washington	397	61.6	472	73.3	701	108.8	554	86.0	1,193	185.2
West Virginia	201	31.2	276	42.8	407	63.2	532	82.6	1,149	178.4
Wisconsin	440	68.3	515	79.9	765	118.8	698	108.4	1,481	229.9
Wyoming	320	49.7	395	61.3	585	90.8	572	88.8	1,229	190.8

	AFDC Family of Two						SSI Couple			
	Maximum AFDC Benefit		Maximum Income Using Standard Deduction (After 12 Months)		Maximum Income with All Work Disregards in Effect		SSI Income (maximum benefit)		With Earned Income	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Jurisdictions with:										
Maximum income less than 25 percent of Poverty Guideline	6	11.8	0	0.0	0	0	0	0.0	0	0.0
Maximum income between 25 and 50 percent of Poverty Guideline	27	52.9	15	29.4	2	3.9	0	0.0	0	0.0
Maximum income between 50 and 75 percent of Poverty Guideline	14	27.5	24	47.1	14	3.9	1	2.0	0	0.0
Maximum income between 75 and 100 percent of Poverty Guideline	4	7.8	12	23.5	20	39.2	42	82.4	0	0.0
Maximum income greater than Poverty Guideline	0	0.0	0	0.0	15	29.4	7	13.7	50	98.0

[1] Assumes that family's monthly income consists only of AFDC payments.

[2] Percentage figure based on annual 1988 Federal poverty guideline for a family of two, $7730 in the forty eight contiguous States.

[3] Assumes that the family is taking the $75 standard deduction. For months 5 to 12 of employment the maximum allowable income equals this amount plus $30.

[4] Assumes that the family is taking $75 standard deduction, in addition, the first $30 of earned income and one-third of the remaining earned income is disregarded.

[5] Assumes that family's monthly income consists only of SSI payments.

[6] Monthly income estimate assumes that $20 monthly income disregard is in effect. In addition the estimate assumes that the first $65 of earned income and one-half of remaining earned income is disregarded.

[7] SSI monthly maximum criterion is for illustrative purposes only. State uses a more restrictive eligibility criteria than the SSI standard to determine Medicaid eligibility. For additional details see Chapter II, "Eligibility."

Note: The maximum allowable income for SSI is based on Federal SSI payments and any State supplemental payment amount.

Source: All figures are Congressional Research Service estimates based on information from the Office of Research and Statistics, Social Security Administration, the Commerce Clearing House, the National Governor's association and the Congressional Research Service.

Since a large share of the SSI eligible are aged, comparing the medically needy levels to the SSI level is more relevant. In 28 States the net income levels for an aged couple living in the community eligible for Medicaid coverage because they are "medically needy" is lower than if the couple is eligible as a result of SSI eligibility (see table A–7).[24] One important implication of this phenomenon is that couples who qualify for Medicaid because they are medically needy will have less income after the payment of their medical expenses than their counterparts who are eligible as a result of SSI eligibility.

This difference in available income occurs because the medically needy threshold is based upon AFDC maximum payments. It should be noted that this phenomenon does not occur in all States, and it occurs in fewer States when one compares the available income for individuals than for couples.

Table A–7.—A COMPARISON OF THE MEDICALLY NEEDY ELIGIBILITY LEVELS WITH THE SSI ALLOWABLE NET INCOME AMOUNT FOR A COUPLE LIVING IN THE COMMUNITY, JULY 1987

State	SSI Level	Medically Needy Level	Difference in Levels	Difference as a Percent of Poverty Guideline
Alabama	$530.00	n.a.	n.a.	
Alaska	957.00	n.a.	n.a.	
Arkansas	530.00	$236.66	$293.34	47.57
California	1,059.00	870.00	189.00	30.65
Colorado	814.00	n.a.	n.a.	n.a.
Connecticut	842.40	603.33	239.07	38.77
Delaware	530.00	n.a.	n.a.	n.a.
District of Columbia	560.00	401.00	159.00	25.78
Florida	530.00	295.00	235.00	38.11
Georgia	530.00	n.a.	n.a.	n.a.
Hawaii	420.00	420.00	0.00	0.00
Idaho	574.00	n.a.	n.a.	n.a.
Illinois [1]	varies	358.00		
Indiana	525.50	525.50	0.00	0.00
Iowa	530.00	453.00	77.00	12.49
Kansas	530.00	480.00	50.00	8.11
Kentucky	530.00	245.00	285.00	46.22
Louisiana	530.00	212.00	318.00	51.57
Maine	609.40	492.40	117.00	18.97
Maryland	530.00	395.00	135.00	21.89
Massachusetts	731.72	570.00	161.72	26.22
Michigan	573.80	570.00	3.80	0.62
Minnesota	533.00	510.00	23.00	3.73
Mississippi	530.00	n.a.	n.a.	n.a.
Missouri	530.00	530.00	0.00	0.00
Montana	530.00	403.00	127.00	20.59
Nebraska	601.50	382.50	219.00	35.51
Nevada	604.46	n.a.	n.a.	n.a.
New Hampshire	531.00	531.00	0.00	0.00
New Jersey	555.36	453.00	102.36	16.60
New Mexico	530.00	n.a.	n.a.	n.a.
New York	622.53	629.00	(6.47)	−1.05

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[24] This comparison assumes that the couple has no earned income, and that the first $20 of any unearned income is disregarded.

Table A-7.—A COMPARISON OF THE MEDICALLY NEEDY ELIGIBILITY LEVELS WITH THE SSI ALLOWABLE NET INCOME AMOUNT FOR A COUPLE LIVING IN THE COMMUNITY, JULY 1987—Continued

State	SSI Level	Medically Needy Level	Difference in Levels	Difference as a Percent of Poverty Guideline
North Carolina	320.00	320.00	0.00	0.00
North Dakota	530.00	420.00	110.00	17.84
Ohio	530.00	530.00	0.00	0.00
Oklahoma	638.00	325.00	313.00	50.76
Oregon	530.00	471.00	59.00	9.57
Pennsylvania	578.80	420.00	158.80	25.75
Rhode Island	634.90	553.33	81.57	13.23
South Carolina	530.00	n.a.	n.a.	n.a.
South Dakota	530.00	n.a.	n.a.	n.a.
Tennessee	530.00	187.00	343.00	55.62
Texas	530.00	n.a.	n.a.	n.a.
Utah	421.00	421.00	0.00	0.00
Vermont	636.40	637.00	(0.60)	−0.10
Virginia	530.00	420.00	110.00	17.84
Washington	552.00	552.00	0.00	0.00
West Virginia	530.00	295.00	235.00	38.11
Wisconsin	695.86	645.00	50.86	8.25
Wyoming	530.00	n.a.	n.a.	n.a.

[1] Illinois makes its State cash supplement recipients automatically eligible for Medicaid, but does not have a flat standard for cash assistance. Since this supplement varies the Illinois SSI maximum is difficult to calculate. Illinois' maximum SSI levels are generally higher than its Medically Needy levels.

Note: "n.a." denotes States that do not offer the Medically Needy eligibility option for Medicaid. All dollar amounts are for policies and standards in effect as of the second quarter of 1987 (effective July 1, 1987 or earlier). New York and Vermont have Medically Needy standards that are slightly higher than the SSI maximum income amounts. Differences for these two States are denoted with parentheses. The difference between SSI and medically needy levels as a percent of poverty is based on the annual poverty guidelines for a family of two. In 1987 this annual guideline was $7,400.

Source: Table 13. in Library of Congress. Congressional Research Service. "Medicaid Eligibility for the Elderly in Need of Long Term Care". CRS Report 87-986 EPW. Prepared under Contract No. 86-26 for the Congressional Research Service by Edward Neuschler with the assistance of Claire Gill, Health Policy Studies, Center for Policy Research, National Governors' Association. September 1987.

5. SUMMARIZING THE EFFECT OF MEDICAID ELIGIBILITY RULES ON THE POOR

The eligibility and payment rules associated with the cash assistance programs result in a patchwork pattern of Medicaid coverage for individuals with incomes below the poverty guidelines. Different types of individuals face different allowable income levels and some individuals no matter how low their income may never be eligible. A summary of these rules is necessary:

—individuals not categorically eligible regardless of income:
  a) childless couples and single persons under 65; [25]
  b) in some States related children over 18 or other individuals living in families eligible for AFDC payments; [26]

—individuals with incomes below the poverty level not categorically eligible for Medicaid include:

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[25] If these individuals are disabled they may be covered by Medicaid through SSI eligibility. This is an important exception that affects the AIDs population. Persons with AIDS may qualify for SSI disability under an expedited process. See Appendix H, "Medicaid and AIDs" for details.

[26] Only parent(s) and related children under 18 are considered a part of the AFDC unit, however in some States related children may be older and still be eligible for Medicaid.

a) married couples with children and an unemployed parent living in States that do not offer Medicaid coverage linked to AFDX–UP coverage;
b) in some States families with earners in low-paying jobs;
c) families relying solely on unearned income (e.g., alimony and child support) when that income exceeds the AFDC payment standard in the State;

—individuals with incomes below the poverty level categorically eligible for Medicaid include:
a) families with AFDC as their only source of income;
b) individuals or couples with SSI as their only source of income residing in States that do not supplement the Federal SSI benefit;
c) families relying on both AFDC and earned income, when this combined income is below the maximum allowable income level in their State.

In certain circumstances, categorical eligibility rules allow for individuals in families with incomes above the poverty line to be eligible for cash assistance payments and Medicaid:

—if a family relies both on AFDC and earned income, depending both on the size of the work disregards it is entitled to and the State the individual resides in; the family's income may be above the poverty threshold and individuals in the family will be categorically eligible for Medicaid;

—if an individual or couple relies on both SSI and earned income, the individuals will be categorically eligible for Medicaid and may have income exceeding the poverty threshold.

Recent legislative changes have altered the link to the cash welfare programs for poor pregnant women and infants. Under the Medicare Catastrophic Coverage Act, Public Law 100–360, beginning July 1989, States must phase-in mandatory Medicaid coverage of pregnant women and infants under 1 year with incomes below the poverty guidelines. In addition, Public Law 100–360 requires States to phase in "buy-in" coverage for poor Medicare beneficiaries.[27]

The next section highlights a number of these aspects of Medicaid coverage by providing estimates of Medicaid coverage rates for the poor and near-poor.

C. PRE-WELFARE INCOME AND MEDICAID COVERAGE

The Census Bureau counts an individual as poor if their family's total cash income from both public and private sources falls below the poverty threshold. This total income includes cash assistance payments. Since categorical eligibility for Medicaid is tied directly to the receipt of AFDC or SSI, the explicit income test for Medicaid eligibility would not count the value of these cash assistance payments. Estimates of Medicaid coverage in this section of the report also will not count any cash assistance payments in comparing a family's income to the poverty threshold. In order to distinguish this income from total family income it will be referred to as pre-welfare income.

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[27] Under Public Law 100–360 States are required to pay Medicare premiums, deductibles and coinsurance for the elderly and disabled whose incomes are at or below the poverty guidelines and who have assets that are less than two times the resources standard used in the SSI program. For additional details on these eligibility rules see Chapter II and Appendix B.

Forty-three percent of the pre-welfare poor were covered by Medicaid in 1986. Perhaps a more important description of the pre-welfare income poor and Medicaid coverage is seen in figure A–6. This figure depicts the coverage rate for the poor taking into account the degree of poverty faced by each individual.

1. THE DEGREE OF POVERTY AND MEDICAID COVERAGE

The likelihood of a poor person being covered by Medicaid is closely related to the degree of poverty a family is facing. Individuals in families with pre-welfare income equal to less than one-fourth of the poverty threshold are much more likely to be covered by Medicaid, than individuals with pre-welfare income closer to the poverty line. For instance, 68 percent of the poor with pre-welfare income less than one-fourth of the poverty line are covered, while 19 percent with incomes that are less than poverty but greater than three-quarters of the poverty threshold are covered.

In 1986, almost 54 percent of the pre-welfare poor had incomes less than half of the poverty threshold. This group's large share of the poverty population and its relatively high Medicaid coverage rates result in this low income group representing 74 percent of the Medicaid covered poor. Table A–8 presents information on the number of pre-welfare poor, the share of the pre-welfare poor covered by Medicaid and other health insurance, and the composition of those covered by Medicaid taking into account an individual's degree of poverty.

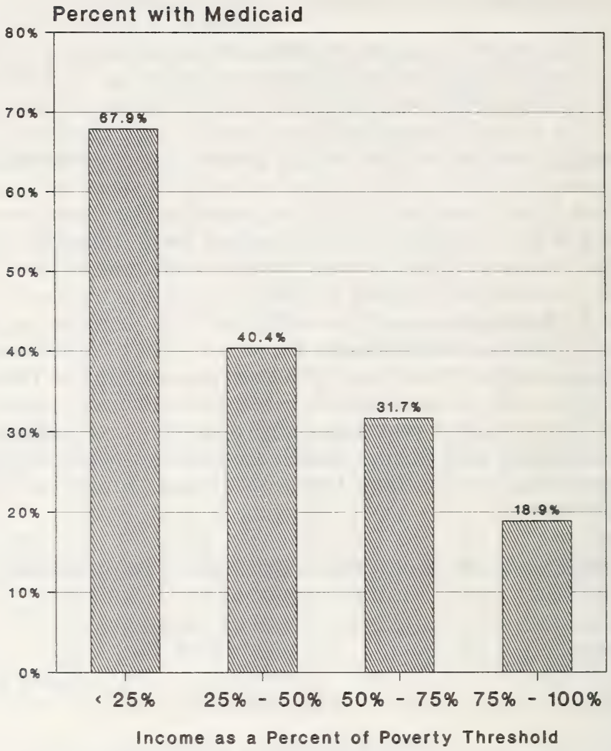
Table A–8.—MEDICAID AND OTHER INSURANCE COVERAGE OF THE PRE-WELFARE POOR POPULATION, 1986

Pre-Welfare Family Income (Measured as a Percent of Poverty)	Covered by Medicaid			Other Insurance	No Insurance	Total
	Only	In Combination	Total			
NUMBER OF INDIVIDUALS (IN THOUSANDS)						
Less than 25 percent	8,060	641	8,701	1,224	2,887	12,811
25 to 50 percent	1,689	608	2,296	1,200	2,192	5,688
50 to 75 percent	1,312	882	2,195	2,050	2,682	6,927
75 to 100 percent	851	869	1,720	4,127	3,262	9,108
Total	11,912	3,000	14,912	8,601	11,023	34,534
INSURANCE COVERAGE RATES (IN PERCENT)						
Less than 25 percent	62.9	5.0	67.9	9.6	22.5	100
25 to 50 percent	29.7	10.7	40.4	21.1	38.5	100
50 to 75 percent	18.9	12.7	31.7	29.6	38.7	100
75 to 100 percent	9.3	9.5	18.9	45.3	35.8	100
Total	34.5	8.7	43.2	24.9	31.9	100

Note: Family's income is measured as income from all sources except SSI, AFDC, and General Assistance. This income amount is compared to the poverty threshold. While the table provides information on respondents with Medicaid in combination with other health insurance, coverage from these two services may not occur simultaneously. Other health insurance category includes respondents who do not have Medicaid coverage,the total count of pre-welfare poor with health insurance coverage other than Medicaid would include individuals in the second column of the table.

Source: All figures are estimates prepared by the Congressional Research Service, Education and Public Welfare Division. These figures are based on information contained in the March 1987 Current Population Survey.

Figure A-6
Medicaid Coverage Rates for Individuals with Income Below Poverty, By Degree of Poverty, 1986



Note: Estimate based on pre-welfare income

Source: March 1987 Current Population Survey

The poor make up a disproportionate share of the uninsured. Almost 32 percent of the pre-welfare poor had no health insurance coverage. But, because of the high Medicaid coverage rate of the poorest of the poor (those with incomes less than one quarter of the poverty threshold), this group has a lower probability of going without health insurance than some higher income categories. The share of individuals covered by Medicaid decreases as the pre-welfare income approaches the poverty threshold. This is partly the result of the restrictive income limits associated with AFDC. In addition, as an individual's income increases and there are greater ties to the work force, there is probably a greater likelihood that the individual will be covered by some other form of health insurance provided by his or her employer. However, individuals in the income range between one-quarter of poverty and the poverty line have the lowest rate of health insurance coverage of the poor.

For the working poor, group and other private insurance coverage may substitute for any loss of Medicaid eligibility.[28] For the aged poor, Medicare provides an alternative (and often complimentary) form of insurance. But, for the remaining groups of the poor there appears to be no alternative insurance source.

2. MEDICAID COVERAGE AND AFDC–UP

Determination of who is eligible for AFDC or SSI has a direct effect on who is eligible for Medicaid. This has two consequences for the Medicaid program. First, if cash assistance program eligibility changes, the number of Medicaid beneficiaries is also likely to change. Appendix C details the impact of some of the changes in AFDC eligibility on poor children's Medicaid coverage. Second, if there is flexibility in defining who is eligible for AFDC programs in different States, there also is likely to be a difference in each State's Medicaid coverage rate. For example, if a State decides to extend AFDC eligibility to two parent families where the primary earner is unemployed (AFDC–UP) the number of poor covered by Medicaid in the State is also likely to increase.[29]

Table A–9 provides Medicaid coverage rates for the nonaged pre-welfare poor in States that extend AFDC eligibility to unemployed parents and States that do not.[30] States with an AFDC–UP program have a Medicaid coverage rate for the nonaged poor that is 1.7 times as high as the rate in States that do not extend eligibility to intact families.[31] The Medicaid coverage rate of the nonaged poor in AFDC–UP States is 61 percent, in States without the AFDC–UP program the Medicaid coverage rate is 36 percent.

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[28] The loss of Medicaid coverage with increased earnings may result in a potential work disincentive. Since an individual either is covered by Medicaid or is not covered by Medicaid—there is a "notch" in health insurance coverage. That is, a point at which health insurance benefits are no longer provided at no expense to the individual. This "notch" is partially the result of many low-wage earners not receiving employer-based health insurance. This is especially the case if these individuals are working part-time. Unlike cash welfare payments where each dollar of cash benefit is substituted by an earned dollar; the working poor face a situation where increased income results in a sudden elimination of Medicaid benefits. In order to offset some of the impact of this notch, Medicaid eligibility rules extend coverage for 4 months to certain families who lose AFDC benefits because of employment and for 9 months (with an optional State extension for an additional 6 months) to families losing AFDC coverage because the earned income disregard no longer applies to the family.

A recent study based on information from the Survey of Income and Program Participation (SIPP) found that over a 34 month period between the fall of 1984 and the Summer of 1986 about 45 percent of those initially reporting Medicaid coverage lost the coverage sometime during the period. Forty-five percent of those losing coverage said it was the result of improved employment status.

[29] Some States provide Medicaid coverage to these families but not cash assistance payments. See chapter II.

[30] Since the AFDC program is primarily comprised of nonaged individuals the analysis in this section will be limited to those under 65.

This differential in the Medicaid coverage rate of the nonaged poor between States that have AFDC–UP programs and States that do not have AFDC–UP programs is partly the result of higher rates of Medicaid coverage in two parent families in the AFDC–UP States. But, AFDC–UP States also have a higher coverage rate for single-parent families than those found in the non AFDC–UP States. In States with AFDC–UP programs 71 percent of the nonaged poor in single parent families are covered by Medicaid, the Medicaid coverage rate for the nonaged poor in families where both parents are present is 48 percent. Comparable rates in non-AFDC–UP States are 52 percent for poor single-parent families, and 16 percent for poor two parent families.

The higher coverage rates for both family types in AFDC–UP States suggests that higher Medicaid coverage of the poor in these States may result from other factors besides the extended coverage to two parent families. For example, States with AFDC–UP programs also may extend Medicaid coverage to the Medically Needy, or allow for additional optional categories of coverage of the categorically needy or set higher income eligibility levels.

Table A–9.—SHARE OF THE NONAGED PRE-WELFARE POOR WITH MEDICAID COVERAGE, OTHER HEALTH INSURANCE COVERAGE OR NO HEALTH INSURANCE COVERAGE, BY TYPE OF STATE, 1986 [1]

	Covered by Medicaid			Other Insurance Only	No Health Insurance	Total
	Medicaid Only	Medicaid and Other	Total			
NUMBER OF INDIVIDUALS (IN THOUSANDS)						
Total Nonaged in Families with Children [1]	10,414	1,183	11,597	4,011	7,377	22,986
AFDC–UP States	7,341	804	8,145	1,999	3,125	13,269
Non-AFDC–UP States	3,073	379	3,452	2,012	4,252	9,717
AFDC–UP States:						
Single Parent	5,092	381	5,473	616	1,653	7,742
Two Parent	2,249	423	2,672	1,383	1,472	5,527
Non-AFDC–UP States:						
Single Parent	2,473	249	2,722	624	1,910	5,257
Two Parent	600	130	730	1,388	2,342	4,460
DISTRIBUTION (IN PERCENT)						
Total Nonaged in Families with Children	45.3	5.1	50.5	17.4	32.1	100
AFDC–UP States	55.3	6.1	61.4	15.1	23.6	100
Non-AFDC–UP States	31.6	3.9	35.5	20.7	43.8	100
AFDC–UP States:						
Single Parent	65.8	4.9	70.7	8.0	21.4	100
Two Parent	40.7	7.7	48.3	25.0	26.6	100

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[31] The Current Population Survey does not allow State-by-State estimates of poverty and Medicaid coverage. The grouping of States into States with AFDC–UP programs and States without AFDC–UP programs is based on information obtained on States participating in the AFDC–UP program during 1986, from the Office of Family Assistance, Family Support Administration DHHS. See Chapter II.

Table A-9.—SHARE OF THE NONAGED PRE-WELFARE POOR WITH MEDICAID COVERAGE, OTHER HEALTH INSURANCE COVERAGE OR NO HEALTH INSURANCE COVERAGE, BY TYPE OF STATE, 1986 [1]—Continued

	Covered by Medicaid			Other Insurance Only	No Health Insurance	Total
	Medicaid Only	Medicaid and Other	Total			
Non-AFDC-UP States:						
Single Parent	47.0	4.7	51.8	11.9	36.3	100
Two Parent	13.5	2.9	16.4	31.1	52.5	100

[1] Nonaged in Families with children under 18 who are related to the head of the household.

Note: Estimates are for individuals under 65 living in families with related children under 18. Determination of poverty is based on a comparison of a family's income excluding AFDC, SSI and General Assistance payments to the appropriate poverty threshold. Determination of which States provide AFDC-UP coverage is based on information obtained from the Department of Health and Human Services (see Chapter II). Respondents to the CPS provide retrospective reporting of health insurance coverage during the previous year, and no questions are asked about dual coverage. Persons with more than one form of insurance coverage may have either had dual coverage or different forms of health insurance at different points of time in the year.

Source: March 1987 Current Population Survey. All estimates prepared by Congressional Research Service, Education and Public Welfare Division.

3. MEDICAID COVERAGE OF THE POOR BY AGE AND INCOME LEVEL

Poor children are more likely to be covered by Medicaid than any other age group. But as figure A-7 shows, the likelihood of their Medicaid coverage is associated with their family's degree of poverty. Medicaid program statistics suggest that a very large share of children are eligible for Medicaid because they are categorically needy (i.e. receiving AFDC payments). These children will tend to live in families with pre-welfare incomes substantially below poverty. Most of those families receiving AFDC payments rely on these payments as their sole form of income. Data on AFDC program characteristics indicate that in 1986, 81 percent of AFDC families had no non-AFDC income.[32] Seventy-eight percent of children living in families with pre-welfare income less than one quarter of poverty are covered by Medicaid. Less than half that rate, about 33 percent of children with pre-welfare incomes between one-half and three-quarters of poverty are covered by Medicaid, and less than 20 percent of children living in families with pre-welfare income between the poverty level and three-fourths of the poverty level are covered by Medicaid. A similar pattern exists for working age adults.

Relatively more liberal SSI maximum allowable income levels result in the aged having higher Medicaid coverage rates at higher income levels than children or working aged adults. For example, 45 percent of the aged with income between one-half and three-quarters of poverty have Medicaid coverage, this is almost twice as high as the coverage rate for working age adults.

On the other hand, the Medicaid coverage rate for the aged with income less than one quarter of the poverty threshold was lower than the rate for children or working age adults. Roughly half of the aged poor with pre-welfare incomes less than one-fourth of the poverty threshold said they were covered by Medicaid. In contrast, 59 percent of working age adults and 79 percent of children in this

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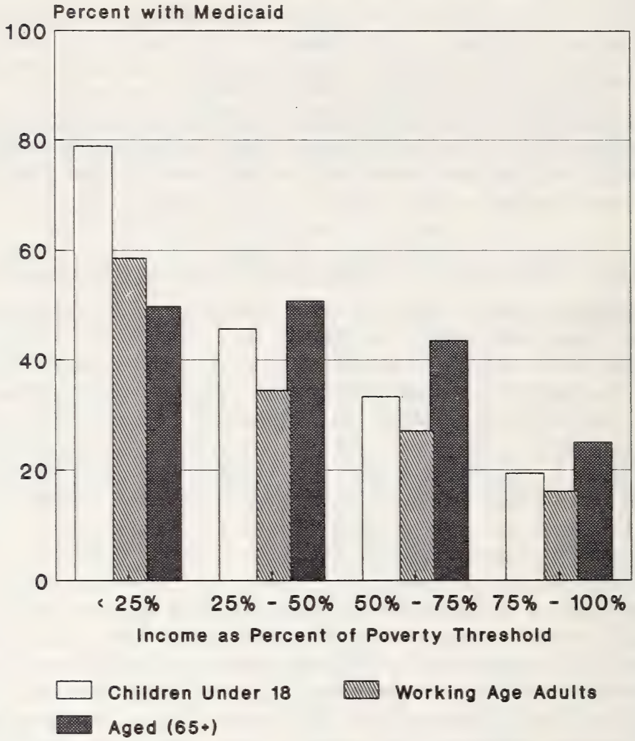
[32] U.S. House of Representatives. Committee on Ways and Means. Background Material on Programs Within the Jurisdiction of the Committee on Ways and Means. 1988 editor, AFDC Characteristics 1969-86, table 21, Mar. 24, 1988. p. 431.

Figure A-7
Medicaid Coverage Rates for Individuals with Pre-Welfare Income Below the Poverty Threshold, 1986



Note: Estimates based on pre-welfare income

Source: March 1987 Current Population Survey

income category said they were covered. Some analysts noting the lower coverage rate of the elderly poor have attributed it to two factors. First, there is an asset as well as an income test associated with SSI. Since our definition of poverty does not consider an individual's assets, it is hypothesized that many of the elderly poor fail to qualify for SSI because of their assets. Second, some studies suggest that the elderly who could qualify for SSI simply do not participate in the program.[33]

4. A SUMMARY OF MEDICAID COVERAGE RATES OF THE POOR

Estimates of the number of poor covered by Medicaid reflect the maximum income limits associated with Medicaid categorical eligibility, and the distribution of individuals by their degree of poverty. The chances of a nonaged poor person having Medicaid coverage is greater if the individual is in a family with very low income levels, in a single-parent family, or residing in an AFDC–UP State. The aged are more likely to be covered by Medicaid at higher income levels than the nonaged. But, the aged poor as an overall group has a lower Medicaid coverage rate than the nonaged.

D. The Near-poor and Medicaid Coverage

Table A–10 provides information on the number of individuals with pre-welfare family incomes in excess of poverty who are covered by Medicaid, other forms of health insurance, or have no health insurance coverage, taking into account their income in relation to the poverty threshold.

Since Medicaid makes provisions for the coverage of the aged and disabled with recurring high medical expenses it is not surprising that individuals with incomes above the poverty threshold are covered. Individuals with recurring medical expenses can have gross cash incomes well above the poverty threshold, only after medical bills result in their "spending down" are these individuals eligible.[34] In 1986, about 24 percent of those individuals covered by Medicaid had pre-welfare incomes above the poverty line. Most of these people had incomes less than twice the poverty level. As an individual's income increases, the likelihood of Medicaid coverage declines: while 1 in 10 individuals with incomes between 100 and 125 percent of poverty were covered by Medicaid, less than 1 in 20 individuals with incomes between 150 and 200 percent of the poverty threshold were covered. For individuals with incomes greater than 2 times the poverty threshold, only 1 in 100 were covered by Medicaid.

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[33] These two factors are discussed in: Brian O. Burwell and Marilyn Rymer, "Trends in Medicaid Eligibility: 1975 to 1985" Health Affairs, Winter 1987, pp. 30–45. While the asset holdings of the elderly are a potential explanation for this phenomenon, the Current Population Survey does not collect this information so it cannot be empirically tested here. There are also some technical explanations that may account for some of this lower coverage. First, the Current Population Survey allows an individual's income to be negative. That is, if an individual's business or farm loses money, the individual's income is below zero. These individuals are counted as poor. Furthermore, since their income is negative they would be counted in the lowest income group in this analysis. For the aged, roughly 3.5 percent of the lowest income category (pre-welfare income less than 25 percent of the poverty threshold) have negative income. All of these individuals are covered by some form of health insurance other than Medicaid. Second, since this is a self-reported survey some individuals may have misreported Medicare coverage for Medicaid.

[34] It should be noted that the Current Population Survey does not survey institutionalized individuals. Individuals in long term care facilities are much more likely to be eligible for Medicaid under the "spend down" provisions of Medically Needy eligibility than those in the community (see Appendix C).

Table A-10.—MEDICAID AND OTHER HEALTH INSURANCE COVERAGE OF PERSONS WITH PRE-WELFARE INCOME OVER THE POVERTY THRESHOLD, 1986

Income as a Percent of Poverty Threshold	Covered by Medicaid			Other Insurance	No Insurance	Total
	Only	In Combination	Total			
NUMBER OF INDIVIDUALS (IN THOUSANDS)						
100 to 125 percent	521	561	1,082	6,093	3,311	10,487
125 to 150 percent	367	433	800	6,885	2,867	10,553
150 to 200 percent	473	563	1,036	16,928	4,770	22,734
200 to 300 percent	424	669	1,094	39,005	6,239	46,338
Over 300 percent	242	604	846	104,150	8,913	113,909
DISTRIBUTION (IN PERCENT)						
100 to 125 percent	5.0	5.3	10.3	58.1	31.6	100
125 to 150 percent	3.5	4.1	7.6	65.2	27.2	100
150 to 200 percent	72.1	2.5	4.6	74.5	21.0	100
200 to 300 percent	0.9	1.4	2.4	84.2	13.5	100
Over 300 percent	70.2	0.5	0.7	91.4	7.8	100

Note: Family income is measured as income from all sources except SSI, AFDC, and General Assistance. This income amount is compared to the appropriate Federal Poverty threshold. While the table provides information on respondents with Medicaid in combination with other health insurance, this other coverage may not occur simultaneously. The "other" health insurance category includes respondents who do not have Medicaid coverage; total other coverage estimates would include those with Medicaid in combination with other forms of health insurance.

Source: All figures are estimates based on information contained in the March 1987 Current Population Survey. All estimates were prepared by the Congressional Research Service, Education and Public Welfare Division.

Persons with annual income above the poverty threshold were much more likely to have said they were covered by some other form of health insurance in addition to Medicaid in 1986. Fifty-eight percent of the nonpoor who were covered by Medicaid during 1986 were also covered by some other form of insurance. This coverage may have occurred simultaneously or at separate times during the year. The person may have had dual health insurance coverage with Medicaid being the secondary payor. For example, medically needy individuals may have "spent down" their incomes on medical services not covered by their other insurance plan (e.g. they may have incurred high prescription drug or long-term care expenses). Or, the person may have experienced a change in economic well being. A person may have been eligible for Medicaid during part of the year, and covered by another form of health insurance during the other part of the year.

1. THE NEAR-POOR MEDICAID COVERAGE AND AGE

Aged individuals with incomes exceeding the poverty threshold had a higher likelihood of being covered by Medicaid, than either children or working age adults. Based on CPS data, nearly 47 percent of all aged Medicaid recipients had pre-welfare income above the poverty threshold (see table A-11). This high share of the near-poor aged with Medicaid coverage is associated with a number of factors. First, the aged are more likely to qualify for Medicaid because they "spend-down" their income (see appendix C). Since "spending down" refers to an individual's net income, these persons are likely to have higher gross incomes. Second, the categorical eligibility income limits for SSI are more likely to allow the aged to have incomes in excess of poverty and still qualify for Medicaid.

It should also be noted that there is nearly universal Medicare coverage of the aged population. For example, all aged persons responding that they were covered by Medicaid also said they were covered by Medicare or other forms of insurance. This means that while a relatively large share of the aged had Medicaid coverage it is highly likely that Medicaid was not the primary payor of many medical services for this group.

Table A–11.—DISTRIBUTION OF PERSONS WITH PRE-WELFARE FAMILY INCOME ABOVE THE POVERTY THRESHOLD BY HEALTH INSURANCE COVERAGE, AND AGE, 1986

	Covered by Medicaid			Other Insurance	No Insurance	Total
	Only	In Combination	Total			
NUMBER OF INDIVIDUALS (IN THOUSANDS)						
Family Income is between 100 and 200 percent of Poverty Threshold:						
Age:						
Under 18	611	361	972	8,376	3,863	13,211
18 to 64	750	564	1,314	14,653	7,024	22,991
65 and over	0	632	632	6,877	60	7,570
Family Income is greater than 200 percent of Poverty Threshold:						
Age:						
Under 18	204	156	360	32,102	3,828	36,289
18 to 64	463	446	909	95,420	11,159	107,489
65 and over	0	672	672	15,633	164	16,470
DISTRIBUTION (IN PERCENT)						
Family Income is between 100 and 200 percent of Poverty Threshold:						
Age:						
Under 18	4.6	2.7	7.4	63.4	29.2	100
18 to 64	3.3	2.5	5.7	63.7	30.6	100
65 and over	0.0	8.3	8.3	90.8	0.8	100
Family Income is greater than 200 percent of Poverty Threshold:						
Age:						
Under 18	0.6	0.4	1.0	88.5	10.5	100
18 to 64	0.4	0.4	0.8	88.8	10.4	100
65 and over	0.0	4.1	4.1	94.9	1.0	100

Note: Family income is measured as income from all sources except AFDC, SSI and General Assistance. This income amount is compared to the appropriate Federal poverty threshold. While this table provides information on respondents with Medicaid in combination with other health insurance, coverage from these two sources may not occur simultaneously. The "Other" health insurance category includes respondents who do not have Medicaid coverage, total "other coverage" estimates would include those with Medicaid in combination with other forms of health insurance. These "other" forms of health insurance include, but are not limited to: Medicare, CHAMPUS, as well as private and employer-based health insurance.

Source: All figures are estimates based on information contained on the March 1987 Current Population Survey. All estimates prepared by the Congressional Research Service, Education and Public Welfare Division.

IV. THE UNINSURED

Most Americans have health insurance coverage. Individuals may obtain this protection either through employment-based plans, private purchases of health insurance or through public plans like Medicaid or Medicare. Medicare's coverage of the aged is nearly universal. The primary source of nonaged health insurance is employer-based plans, while the primary source of government financed medical service coverage for the nonaged is Medicaid. But, as has been already discussed, eligibility for Medicaid is restricted to those deemed "needy."

Whether an individual does or does not have health insurance is influenced by a number of factors. Among these are: an individual's age; an individual's family relationships; an individual's attachment to the labor force; and an individual's earnings.[35] A number of these factors are associated with the racial/ethnic makeup of the uninsured. The demographic characteristics of the uninsured are highlighted in Table A–12.

Table A–12.—SELECTED DEMOGRAPHIC CHARACTERISTICS OF INDIVIDUALS WITHOUT HEALTH INSURANCE COVERAGE, 1986

	Covered by Medicaid			Other insurance only	No health insurance	Total
	Medicaid only	Medicaid and other insurance	Total			
NUMBER OF INDIVIDUALS (IN THOUSANDS)						
Age:						
Under 18	7,364	1,108	8,472	42,474	12,001	62,948
18 to 64	6,576	1,973	8,548	114,266	24,817	147,631
65 and over	0	2,749	2,749	24,922	304	27,975
Family Type:						
Families with related children under 18:						
Single parent	7,312	803	8,115	8,674	5,976	30,879
Two parent	3,297	1,363	4,660	81,974	11,983	103,276
Children 18 and over and others	1,310	355	1,665	6,890	3,979	14,201
Families without related children under 18:						
In families	1,077	1,800	2,877	60,376	9,706	75,836
Single individuals	944	1,509	2,452	23,747	5,479	34,131
Race/Ethnicity:						
White (non-Hispanic)	6,099	3,699	9,797	151,316	23,004	184,119
Black (non-Hispanic)	4,798	1,306	6,105	15,681	6,673	28,459
Hispanic	2,460	569	3,030	9,727	6,001	18,758
Other (non-Hispanic)	583	255	838	4,937	1,444	7,220
Total	13,940	5,830	19,770	181,662	37,123	238,554
DISTRIBUTION (IN PERCENT)						
Age:						
Under 18	11.7	1.8	13.5	67.5	19.1	100.0
18 to 64	4.5	1.3	5.8	77.4	16.8	100.0
65 and over	0.0	9.8	9.8	89.0	1.1	100.0

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[35] See U.S. House of Representatives. Subcommittee on Health and the Environment. Committee Print. Serial 100–X. "Health Insurance and the Uninsured: Background Data and Analysis." by the Congressional Research Service, Library of Congress. May 1988. p. 96.

Table A–12.—SELECTED DEMOGRAPHIC CHARACTERISTICS OF INDIVIDUALS WITHOUT HEALTH INSURANCE COVERAGE, 1986—Continued

	Covered by Medicaid			Other insurance only	No health insurance	Total
	Medicaid only	Medicaid and other insurance	Total			
Family Type:						
Families with related children under 18:						
Single parent	23.7	2.6	26.3	28.1	19.4	100.0
Two parent	3.2	1.3	4.5	79.4	11.6	100.0
Children 18 and over and others	9.2	2.5	11.7	48.5	28.0	100.0
Families without related children under 18:						
In families	1.4	2.4	3.8	79.6	12.8	100.0
Single individuals	2.8	4.4	7.2	69.6	16.1	100.0
Race/Ethnicity:						
White (non-Hispanic)	3.3	2.0	5.3	82.2	12.5	100.0
Black (non-Hispanic)	16.9	4.6	21.5	55.1	23.4	100.0
Hispanic	13.1	3.0	16.2	51.9	32.0	100.0
Other (non-Hispanic)	8.1	3.5	11.6	68.4	20.0	100.0
Total	5.8	2.4	8.3	76.2	15.6	100.0

Note: Insurance coverage for families with related children are for parents and related children under 18 in these families, all other family members are found in the "children 18 and over and others" category. The CPS does not ask questions about dual health insurance coverage. Individuals responding that they were covered by more than one form of health insurance in 1986, may either have had dual coverage, or different forms of insurance at different times of the year.

Source: March 1987 Current Population Survey. All numbers are estimates prepared by Education and Public Welfare Division, Congressional Research Service.

A. The Uninsured and Income

Based on estimates from the March 1987 Current Population Survey, approximately 37.1 million (15.6 percent) Americans had no health insurance coverage in 1986. The poor and near-poor represented a disproportionately large share of the uninsured (i.e., their share of those without health insurance is larger than their share of the total population). Fifty-nine percent of the uninsured had pre-welfare incomes below 200 percent of the poverty threshold, individuals in these income categories represented 33 percent of the total population (see figure A–8).

B. The Uninsured and Family Type

Private insurance plans often tie eligibility to the "immediate family." Generally, this insurance unit will consist of the enrollee of the plan, his or her spouse, and dependent children below a certain age (typically 22 or 25, depending on the insurer). As we have already detailed, Medicaid coverage is based on membership in selected "needy" families. Like private insurance, this coverage is limited to parents and related children. The effect of these eligibility rules on the uninsured is reflected in the composition of the uninsured.[36]

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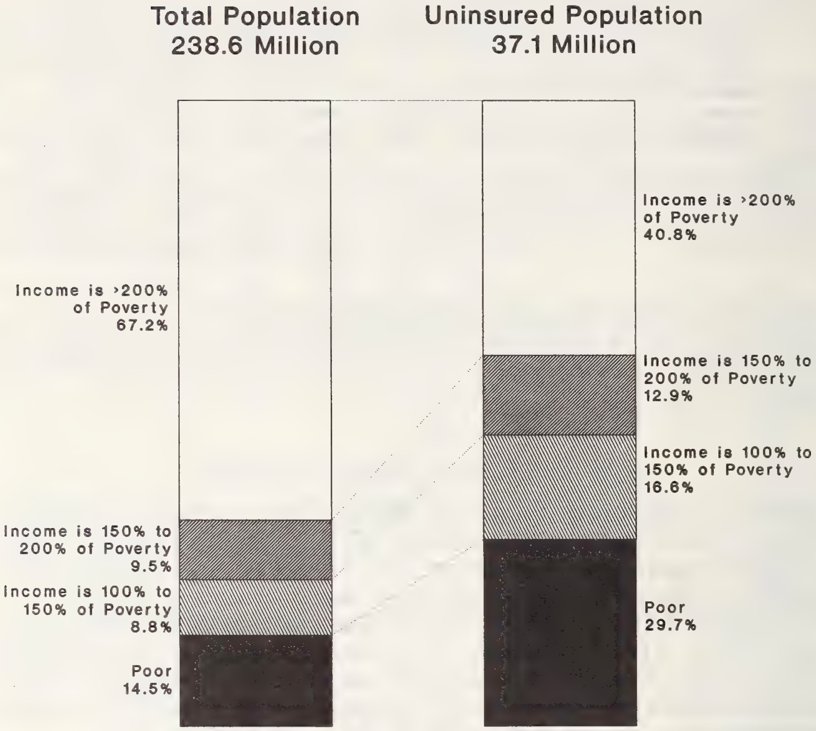
[36] See U.S. House of Representatives, Energy and Commerce. "Health Insurance and the Uninsured: Background Data and Analysis." by the Congressional Research Service, Library of Congress. Committee Print. Serial No. 100–X. Washington 1988.

Figure A-8
Comparison of the Uninsured and Total Population, by Income, 1986



Note: Based on pre-welfare income.
Source: March 1987 CPS.

Figure A–9 displays the uninsured by family type. Since families with children are more likely to have Medicaid coverage, the figure divides the population of uninsured into two major parts: individuals living in families with children, and individuals living in families without children. The largest portion (59 percent) of uninsured live in families with related children. However, 7 percent of these persons are outside of the standard AFDC unit, and some private health insurance units. Of the remaining people in these families, a large majority (34 percent) are in two parent families; these are families that have a very low Medicaid coverage rate.

C. The Uninsured and Age

The largest share of the uninsured, over two-thirds, are people between the ages of 18 and 64. Another 32 percent of the uninsured are children under 18. The aged make up less than 1 percent of all those without any health insurance.[37] The lack of health insurance among those between 18 and 64 is closely related to their labor force involvement. Those relatively young, with part-time labor force attachments and low earnings are much less likely to have employer-based health insurance when compared to older workers, with full-time attachments to the labor market. Neither of these working age groups are likely to be eligible for Medicaid.

D. The Uninsured and Race/Ethnicity

Thirty-two percent of Hispanic survey respondents said they had no health insurance coverage during 1986. This rate is much higher than the rates for blacks (23 percent), and the rate for whites (12.5 percent). Two aspects of Hispanic poverty are likely contributors to this high rate. First, many poor Hispanics live in two-parent families, families that are less likely to be covered by Medicaid.[38] In addition, Hispanic attachment to the labor market differs from other groups. A number of the characteristics of Hispanic labor force attachment are associated with lower probabilities of employer-based health insurance coverage. Generally, Hispanic fathers and mothers worked fewer hours than non-Hispanic white parents. Part-time attachment to the labor force is associated with lower rates of employer-based health coverage. When compared to other racial/ethnic categories, a relatively large share of Hispanics work in farm occupations, a major industry that is less likely to offer employment-based health insurance than other sectors of the economy.[39]

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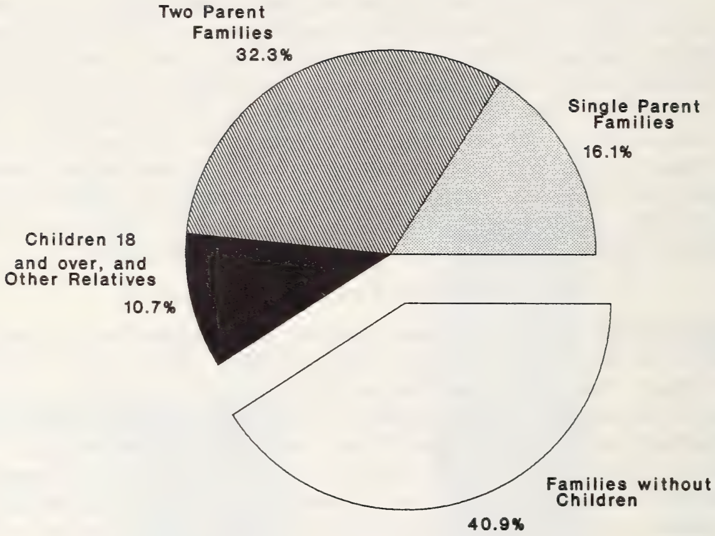
[37] Responses to health insurance questions on the Current Population Survey do not include information on types of services covered. While the elderly do not represent any sizable portion of the uninsured, many are still subject to the out-of-pocket risk of medical expenses associated with long term care services, some prescription drug expenses and other noncovered services.

[38] See U.S. Library of Congress. Congressional Research Service. Hispanic Children in Poverty. CRS Report No. 85–170 EPW, by Vee Burke, Thomas Gabe, Richard Rimkunas and Jeanne Griffith. Washington D.C. September 13, 1985.

[39] In 1983, 10.3 percent of Hispanic fathers in married couple families who worked, worked in farming, forestry and fishing occupations. The share of now-Hispanic whites in this occupation category was 4.3, the share of non-Hispanic blacks was 4.2. Over 5 percent of Hispanic mothers who worked had a farm occupation. This compares with 1.4 percent of non-Hispanic white mothers and 1.0 percent of non-Hispanic black mothers. See U.S. Library of Congress, Congressional Research Service. Hispanic Children in Poverty. CRS Report No. 85–170 EPW, by Vee Burke, Thomas Gabe and Jeanne Griffith. Washington D.C., September 13, 1985.

Figure A-9
Persons not Covered by Health Insurance by Family Status, 1986



Source: March 1987 CPS

APPENDIX B. MEDICAID AND CHILDREN [1]

INTRODUCTION

One-half of the Medicaid beneficiaries who received services in FY1986 (11.3 million) were children under age 21.[2] Despite the fact that a relatively large share of Medicaid beneficiaries are children, they account for a comparatively small share of Medicaid payments. Payments for children were only 20 percent ($8.0 billion) of total Medicaid payments in FY1986 (see figure B-1).

Why do children make up such a large share of the Medicaid population, yet such a relatively small share of Medicaid payments? This appendix will explore this question by examining the health care needs of children and the role of Medicaid in financing their care. The appendix shows:

—*Children generally have patterns of illness which are different from those of adults.* Children may become ill more often, but their illnesses are generally less serious and are often "self-curing." Of course, some children become very ill, while others develop minor children's illnesses which may turn quite serious if they remain unchecked. As a result, children often require primary care services, including preventive services.

—*Some children require care for chronic conditions, conditions which last for a substantial period of time.* About 10 to 20 million children are affected by some chronic disorder; most of these children have mild chronic conditions, such as mild cases of asthma. The chronic conditions of about 1 to 5 percent of all children regularly limit their daily life activities, such as severe mental retardation. On average, chronically disabled children use more medical services and have higher health costs than other children.

—*Data on the use of Medicaid services by children reflect the patterns of health care described above.* Ambulatory care services, such as physician's services and outpatient hospital services, are the most widely used. As a result of higher per beneficiary costs, payments for inpatient hospital services represent the

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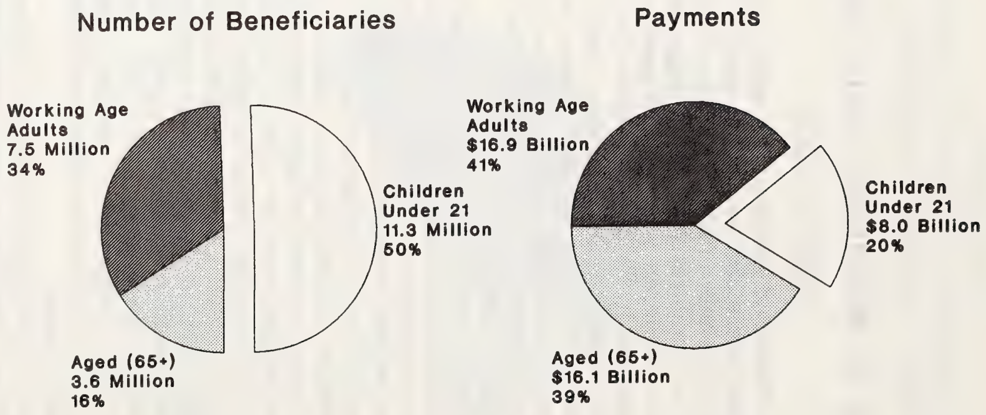
[1] This appendix was prepared by Joseph Cislowski. Keith Hurt prepared estimates of Medicaid coverage of children and developed the computer graphics for the appendix.

[2] Some of the data on Medicaid beneficiaries and payments presented in this appendix are obtained from HCFA-2082 forms (Statistical Report on Medical Care: Recipients, Payments, and Services) which provide a variety of information on Medicaid beneficiaries and payments. Beneficiary information is provided both by age of beneficiary and by beneficiary eligibility status. The data presented in figures B-1 and B-2 and table B-3 are based on the age of the beneficiary. The data presented in tables B-2 and B-4 are based on beneficiary eligibility status. Information based on age includes not only children eligible because they are in families with dependent children, but also children eligible for Medicaid because of disabilities, and other children such as Ribicoff children. Children, as defined by eligibility status, are only those children in families with dependent children (whether or not they are receiving cash assistance). Beneficiary and payment amounts for children based solely on age will always be larger than the amounts for dependent children based on eligibility.

Figure B-1
Medicaid Beneficiaries and Payments,
By Age of Beneficiaries, FY 1986



Source: HCFA-2082 forms. Figure prepared by Congressional Research Service, Education and Public Welfare Division.

largest share of Medicaid spending on children. The high costs of the treatment of chronic conditions and inpatient hospital services helps explain why infants and older children have higher per capita expenditures than other children.

—*Four-fifths of all children are covered by some form of private or public health insurance.* Most children with health coverage are covered by private health insurance plans (primarily employment-based plans). Some children rely on government-based health plans as an insurance source. Medicaid covers roughly one-half of all poor children. Medicaid has not covered a larger share of poor children because eligibility has generally been linked to the receipt of cash welfare, which has generally been available to families where the child is deprived of the support of at least one parent. In addition, families have been required to meet State income eligibility standards which are below Federal poverty guidelines. Congress has recently acted to disconnect the eligibility link between Medicaid and cash welfare for some pregnant women and children.

—*Medicaid can be an important source of financing for disabled children.* Such children, however, may receive Medicaid benefits only if they and their families meet their State's Medicaid eligibility standards. Additional disabled children not otherwise eligible for Medicaid may become eligible while institutionalized; however, until recently, such children rarely would have been eligible for equivalent care at home. Medicaid law now allows States to expand eligibility and increase covered services for the home care of disabled children.

This appendix provides background information on Medicaid and children. The first section discusses the health care needs of children, including their primary care and chronic care needs. The second section examines the role of Medicaid in the financing of children's health care. It begins with background information on children's health insurance coverage, including Medicaid coverage. The background information is followed by separate discussions of Medicaid coverage of poor children and of children with disabilities. Finally, the appendix contains related data on Medicaid spending and information on other financing sources for children's health care.

I. HEALTH CARE NEEDS OF CHILDREN

Children generally have patterns of illness which are different from those of adults. Children may become ill more often, but their illnesses are generally less serious and are often "self-curing." Of course, some children become very ill, while others develop minor children's illnesses which may turn quite serious if they remain unchecked (e.g., if left unattended, otitis media, recurrent middle ear infection, may result in significant hearing loss). Some children also face developmental and behavioral problems.[3]

As a result of these patterns of illness, the health care needs of children differ from those of adults. The first section of this appendix describes both the primary care and chronic care needs of children. The Medicaid program is designed to address both of those needs.

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[3] Harvard Child Health Project Task Force. Toward a Primary Medical Care System Responsive to Children's Needs. Cambridge, Massachusetts, Ballinger Publishing Company, 1977. p. 1, 7–8.

A. Primary Care for Children

1. PRIMARY CARE SERVICES

Some health analysts maintain that children's patterns of illness indicate the need for children's health services to focus on primary care.[4] This type of care is generally the care provided at the point where the child enters the health care system and receives basic ambulatory services. Primary care often involves a continuing relationship between physician (or other health professional) and patient, even in the absence of disease. It is at this level that the child is usually integrated into all other aspects of health care.[5]

Most children require episodic treatment for acute illnesses. Common illnesses include ear infections, upper respiratory infections, sore throats, tonsillitis, and bronchitis. According to the 1985 National Ambulatory Medical Care Survey, there were 118.8 million visits by children under 15 to physicians' offices in 1985. The top 15 principal reasons for these visits are listed in table B-1.

Table B-1.—TOP 15 REASONS FOR VISITS TO PHYSICIANS' OFFICES [1] BY CHILDREN UNDER AGE 15, 1985

Rank	Principal reason for visit	Percentage of visits
1	Well-baby exam	13.8
2	Cough	6.6
3	Fever	6.4
4	Earache or ear infection	6.0
5	General medical examination	4.9
6	Throat symptoms	4.9
7	Head cold/upper respiratory infection	3.1
8	Skin rash	3.1
9	Nasal congestion	2.2
10	Physical examination required for school	1.3
11	Vomiting	1.3
12	Allergy not otherwise specified	1.2
13	Otitis media (middle ear infection)	1.2
14	Prophylactic inoculations	1.1
15	Allergy medication	1.1
	All others	41.7

[1] Excludes settings not considered a physician's private office, such as part-time offices, hospital emergency rooms, other hospital outpatient clinics, school clinics, and family planning clinics.

Source: National Center for Health Statistics. Unpublished data from the 1985 National Ambulatory Medical Care Survey.

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[4] Harvard Child Health Project Task Force, Toward a Primary Medical Care System Responsive to Children's Needs, p. 1.

[5] U.S. Department of Health Education and Welfare. The Education of Physicians for Primary Care. Prepared by Joel J. Alpert and Evan Charney. (DHEW Pub. No. (HRA) 74-3113). Washington, 1973. p. 1-3.

Haggerty, Robert J. Graduate Physician Training in Primary Care. Journal of Medical Education, v. 49. Sept. 1974. p. 840.

Capron, William. Issues of Organization and Financing of Delivery Systems. In Harvard Child Health Project Task Force. Developing a Better System for Child Health. Cambridge, Massachusetts, Ballinger Publishing Company, 1977. p. 4.

As table B–1 shows, children not only visit physicians' offices for treatment of acute illnesses, but also for preventive health care. According to the American Academy of Pediatrics (AAP), preventive care enables children to achieve optimal physical, intellectual, and emotional growth and development, and offers them a better chance to develop into healthy and productive adults.[6] Preventive health care for children is designed not only to prevent the occurrence of childhood diseases, but also to prevent those diseases which do occur from becoming more severe and destructive.[7] For example, infectious diseases may spread further and may result in progressive deterioration if not identified and treated at an early stage. Early diagnosis and treatment of certain orthopedic conditions may reduce the risk and severity of complications. Early detection of certain visual defects may reduce ermanent vision problems.[8]

One preventive service of importance to children actually takes place before their birth. Prenatal care has been proven to be an ffective way to reduce the incidence of low birth weight, a major determinant of infant mortality.[9] Adequate prenatal care encourages behavioral changes that improve the mother's health and nutrition (e.g., cessation of smoking or improved diet). It may also uncover medical conditions (e.g., hypertension or iron deficiency anemia) that with appropriate treatment may not be as threatening to the infant's health.[10] The American College of Obstetricians and Gynecologists (ACOG) recommends that prenatal care begin as early in the first trimester of pregnancy (3 months) as possible. Women with uncomplicated pregnancies should be seen every 4 weeks for the first 28 weeks of pregnancy, every 2 to 3 weeks for the next 8 weeks, and weekly thereafter until delivery. ACOG suggests that women with medical or obstetric problems be seen more frequently.[11]

The AAP's Committee on Practice and Ambulatory Medicine has developed guidelines for health supervision of children and youth. In addition to recommendations on prenatal care, the AAP suggests the following series of preventive well-child visits for most children: six during infancy (under 1 year old), five during early childhood (age 1 to 4), five during late childhood (age 5 to 12), and four during adolescence (beginning at age 14). The care recommended for these well-child visits includes medical histories, measurements, sensory screening, developmental and behavioral assessments, physical examinations, specified procedures, anticipatory guidance, and an initial dental referral.

Information on the overall effectiveness of well-child services in improving children's health status is limited. Certain practices, such as childhood immunizations, have been proven effective and cost-effective. The level of effectiveness of certain other well-child services, such as regular general physical examinations for children, has not been clearly demonstrated.[12]

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[6] American Academy of Pediatrics. Committee on Standards of Child Health Care. Standards of Child Health Care. 3rd ed. Evanston, Illinois, American Academy of Pediatrics, 1977. p. 9.

[7] Harvard Child Health Project Task Force, Toward a Primary Medical Care System Responsive to Children's Needs, p. 1–2.

[8] American Academy of Pediatrics. Unpublished materials.

[9] Institute of Medicine. Committee to Study the Prevention of Low Birthweight. Preventing Low Birthweight. Washington, National Academy Press, 1985. p. 37.

[10] Griffith, Jeanne E., and Joseph A. Cislowski. Infant Mortality: Are We Making Progress? Congressional Research Service Review, Jan. 1986. p. 13.

[11] American College of Obstetricians and Gynecologists. Committee on Professional Standards. Standards for Obstetric-Gynecologic Services. Washington, 1985.

2. USE OF PRIMARY CARE SERVICES

A number of government and academic studies have examined children's access to medical care through the analysis of responses to health care surveys, including the 1980 National Medical Care Utilization and Expenditure Survey (NMCUES). While this survey is somewhat dated and has other limitations, it is among the best national sources of information available for examining the use of medical care among children.

One indicator of children's access to care is the availability of a "regular source" of ambulatory medical care. These sources—including private physicians' offices, group practices, public clinics, and hospital outpatient departments—should provide children with appropriate medical care or referrals. According to NMCUES data, 91.9 percent of all children under age 18 were reported by their parents to have a regular source of care.[13]It is important to note that some of the parents responding may have reported access to sources such as hospital emergency rooms, which are not generally considered to be adequate or cost-effective sources of regular care for children.[14] The likelihood of having a regular source varied only slightly by age, and somewhat more by family income level and race or ethnicity. The poor were less likely to have a regular source. Blacks and Hispanics were also less likely to have such a source.

About three-fourths (75.5 percent) of all children reported at least one medical care visit in 1980; the mean number of visits reported per child was 3.3. There were large differences among age groups; children from 0 to 2 years old had the lowest rate of children with no visits (8.0 percent) and the highest number of visits per child (5.3 per year). Among income levels, those children whose family incomes were just above poverty (between 100 and 150 percent of the poverty line) were less likely to have seen a medical care provider in the past year (33.3 percent had no visits, 2.6 average visits per child) than those children in both better and worse financial circumstances. About one-third of all black (35.0 percent) and Hispanic (33.4 percent) children did not have a medical visit in the previous year, compared to 21.3 percent of white children; the average number of visits per black (2.1 per year) and Hispanic (2.4 per year) child was lower than the number per white child (3.7 per year).

Coverage under Medicaid or other health insurance plans also determines the use of medical care by children, according to another 1980 NMCUES analysis.[15] Among the low-income children (i.e., children with family incomes below 150 percent of the Federal poverty level) surveyed, those without Medicaid coverage were more likely to go without a physician visit (32.6 percent) than those with Medicaid coverage (24.8 percent). Some of the low-income children without Medicaid coverage did have private health insurance coverage; however, those with neither Medicaid nor private insurance were even more likely to have gone without a medical visit (36.3 percent).

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[12] U.S. Congress. Office of Technology Assessment. Healthy Children: Investing in the Future. Washington, U.S. Govt. Print. Off., 1988. p. 119–135.

[13] Butler, John A., William D. Winter, Judith Singer, and Martha Wenger. Medical Care Use and Expenditure Among Children and Youth in the United States: Analysis of a National Probability Sample. Pediatrics, v. 76, Oct. 1985. p. 497.

[14] Office of Technology Assessment, Healthy Children, p. 53–54.

Similarly, low-income children with Medicaid or private health insurance were more likely to see a physician more frequently than those without such coverage. For example, the average number of visits for low-income children covered by Medicaid (2.9 per child) exceeded the average for uninsured low-income children (1.8 per child).

3. MEDICAID SERVICES

Data on the use of Medicaid services by dependent children under 21 reflect the patterns of health care use as described above (see table B–2). Ambulatory care services were the most widely used services; 6.5 million children used physician's services and 4.5 million used outpatient hospital services in FY1986; 6.0 million children used prescribed drugs. Intermediate care facility services for the mentally retarded were the services least extensively used by dependent children under age 21 (374 received them); of course, these services are used to a much greater extent by Medicaid-eligible children who are placed in Medicaid's disabled category rather than in the dependent child category.

a. Medicaid expenditures. Even though ambulatory care services (e.g. physicians and outpatient health services) are the services most widely used by children, inpatient hospital services account for the largest share of Medicaid expenditures for dependent children under age 21 (see table B–2). Medicaid paid $2.4 billion for inpatient hospital services in FY1986 for such children, representing 47.0 percent of all Medicaid payments for children. Whereas, Medicaid paid $684 million on physician's services (13.3 percent) and $656 million on outpatient hospital services (12.8 percent). This percentage distribution can be explained by the fact that per capita payments for inpatient hospital services are much higher than those for ambulatory services. In fact, only the other institutional services (i.e., inpatient psychiatric facility, skilled nursing facility, and intermediate care facility services) have higher payments per dependent child under age 21 using these services.

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[15] Rosenbach, Margo L. Insurance Coverage and Ambulatory Medical Care of Low-Income Children: United States, 1980. National Medical Care Utilization and Expenditure Survey. Series C, Analytical Report No. 1. DHHS Pub. No. 85–20401. National Center for Health Statistics, Public Health Service. Washington, U.S. Govt. Print. Off., Sept. 1985. p. 15.

Table B–2.—MEDICAID PAYMENTS FOR DEPENDENT CHILDREN UNDER AGE 21, BY SERVICE TYPE, FISCAL YEAR 1986

Type of service	Number of dependent children under age 21 using service	Vendor payments for dependent children under age 21 using service	Payments per dependent child under age 21 using service
Total for all services [1]	10,030,673	$5,135,752,591	$512
Inpatient hospital services	923,677	2,412,003,489	2,611
Inpatient psychiatric facility services for individuals age 21 and under	11,357	144,052,708	12,684
Intermediate care facility services for the mentally retarded	374	12,724,091	34,022
Intermediate care facility services—all other	525	8,575,250	16,334
Skilled nursing facility services	560	7,720,056	13,786
Physicians' services	6,495,370	684,097,232	105
Dental services	2,738,532	232,677,803	85
Other practitioners' services	1,097,881	71,875,231	65
Outpatient hospital services	4,447,779	656,397,037	148
Clinic services	874,370	169,956,800	194
Home health services	69,411	23,932,266	345
Family planning services	314,147	32,079,864	102
Laboratory and x-ray services	2,481,231	105,363,482	42
Prescribed drugs	5,948,508	295,896,999	50
Early and periodic screening	1,908,903	90,937,578	48
Rural health clinic services	51,435	4,380,857	85
Other care [2]	787,928	183,081,848	232

[1] Unduplicated count.

[2] Includes services to children in health maintenance organizations.

Source: HCFA–2082 forms.

b. Variation by age. Children of different ages use different levels of Medicaid services. For example, the likelihood of inpatient hospitalization is generally greater for very young children and for older teenage children. Older disabled children are high users of long-term care services.[16]

This pattern is reflected in Medicaid expenditures. Figure B–2 and table B–3 show that, in the States selected, infants (under age 1) and older children (age 15–20) had higher per capita expenditures than young children (age 1 to 14).[17] In Idaho, for example, FY1986 payments per infant under age 1 were $1,565. The per capita amount dropped to $573 for children age 1–5, and increased slightly to $628 for children age 6–14. The amount rose to $1,612 for children age 15–20.

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[16] Rymer, Marilyn P., and Gerald S. Adler. Children and Medicaid: The Experience in Four States. Health Care Financing Review, v. 9, no. 1, fall 1987. p. 12–15.

[17] The data used come from the three States—Idaho, South Dakota, and Virginia—which completed a new version of the HCFA–2082 form and which reported data that was consistent across different sections of that form for children's payment and beneficiary counts.

Table B–3.—MEDICAID PAYMENTS PER BENEFICIARY UNDER AGE 21 IN SELECTED STATES, BY AGE, FISCAL YEAR 1986

State	Total payments (in thousands of dollars)	Number	Payment per child
		Under 1	
Idaho	$2,742	1,752	$1,565
South Dakota	4,177	2,028	2,060
Virginia	13,255	15,452	858
		1 to 5	
Idaho	425	7,431	573
South Dakota	4,414	6,146	718
Virginia	22,552	49,797	453
		6 to 14	
Idaho	4,782	7,617	628
South Dakota	5,443	6,365	855
Virginia	22,639	54,935	412
		15 to 20	
Idaho	5,794	3,595	1,612
South Dakota	5,066	2,907	1,743
Virginia	33,382	32,117	1,039
		Total	
Idaho	17,574	20,395	862
South Dakota	19,100	17,446	1,095
Virginia	91,828	152,301	603

Source: HCFA–2082 forms.

c. Variation by State. States have considerable discretion in selecting the services covered by their Medicaid plans. As described in chapter III, some services are required to be covered by the States (e.g., physician or inpatient hospital services), while others may be covered at State option (e.g., prescription drugs, eyeglasses, and dental care). States may limit the amount, duration, and scope of Medicaid services.[18]

Eligibility requirements and reimbursement levels also vary significantly from State to State. As a result of these variations, children with identical health characteristics and family income levels may receive different benefits under Medicaid, depending on the State in which they live. State Medicaid expenditures reflect these variations. Table B–4 shows that FY1986 Medicaid payments per child beneficiary ranged from $285 in South Carolina to $775 in Alaska.[19]

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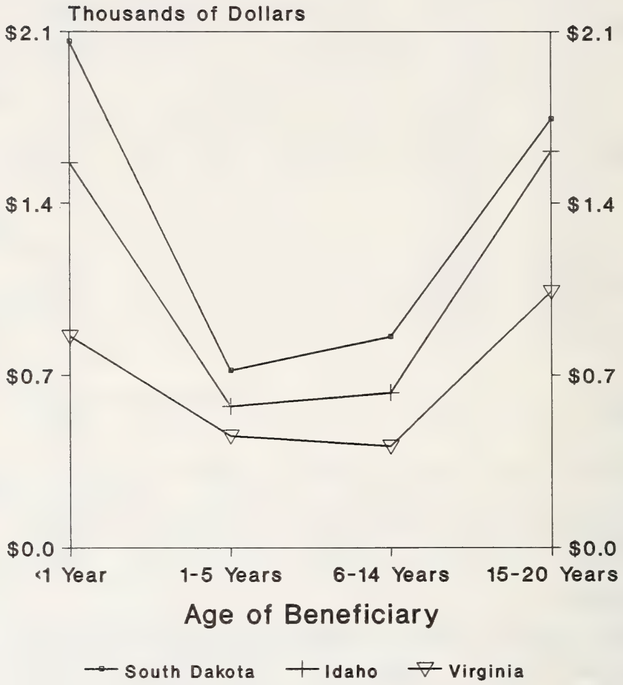
[18] For a detailed description of the Medicaid services covered by each State, see chapter III. In order to simplify the language in this appendix, the District of Columbia will at times be referred to as a State.

[19] Ohio's FY1986 Medicaid spending per child beneficiary equalled $1,167. In 1985 Ohio's Medicaid spending per child equalled $568. It is not clear why there has been a two-fold increase in payments per beneficiary in this State.

Figure B-2
Medicaid Payments Per Child Beneficiary, By Age, In Selected States, FY 1986



Source: HCFA-2082 forms. Figure prepared by Congressional Research Service, Education and Public Welfare Division.

Despite the fact that a relatively large share of Medicaid beneficiaries are children, they account for a comparatively small share of Medicaid payments. This pattern is evident in each State, as seen in table B-4. In FY1986, while the proportion of Medicaid beneficiaries who were dependent children under age 21 ranged from 27.9 percent in New Hampshire to 66.3 percent in Ohio, the proportion of total payments for children ranged from 3.0 percent in New Hampshire to 26.3 percent in Ohio.

Table B-4.—MEDICAID PAYMENTS FOR DEPENDENT CHILDREN UNDER AGE 21, BY STATE, FISCAL YEAR 1986

State	Number of dependent children under age 21	Number of dependent children as percent of total beneficiaries	Total payment for dependent children under age 21	Payments for dependent children as percent of total beneficiaries	Payments per dependent child under age 21
Alabama	116,029	36.7	$39,477,277	9.6	$340
Alaska	15,176	52.8	11,766,750	13.8	775
Arkansas	61,214	30.1	38,838,401	9.0	634
California	1,375,980	39.7	585,188,096	13.3	425
Colorado	68,286	45.8	27,222,339	9.1	399
Connecticut	94,288	43.5	57,268,892	8.5	607
Delaware	18,945	48.2	9,270,123	11.7	489
District of Columbia	45,365	46.3	16,688,511	8.3	368
Florida	236,711	40.3	83,377,758	8.3	352
Georgia	221,769	45.9	93,961,534	11.5	424
Hawaii	47,335	53.2	19,777,993	14.5	418
Idaho	18,436	45.8	9,245,314	10.8	501
Illinois	542,076	51.0	256,659,472	15.3	473
Indiana	144,763	48.6	88,674,172	10.7	613
Iowa	103,193	46.5	48,107,530	12.8	466
Kansas	69,060	52.7	27,341,358	11.5	396
Kentucky	191,145	46.1	66,600,453	12.4	348
Louisiana	193,940	43.4	98,693,193	12.7	509
Maine	61,838	49.4	29,766,473	10.5	481
Maryland	161,259	49.9	116,161,902	17.1	720
Massachusetts	188,496	35.6	133,303,552	8.0	707
Michigan	625,516	55.9	290,338,110	16.4	464
Minnesota	138,308	40.2	62,767,731	6.0	454
Mississippi	126,920	39.8	38,276,583	12.1	302
Missouri	152,861	42.5	67,171,868	12.1	439
Montana	21,733	41.6	11,126,301	9.9	512
Nebraska	42,449	41.6	20,510,548	10.9	483
Nevada	13,122	40.3	7,989,417	10.1	609
New Hampshire	9,864	27.9	3,949,026	3.0	400
New Jersey	295,179	50.8	143,404,045	11.2	486
New Mexico	41,104	44.8	25,451,429	15.4	619
New York	989,349	42.6	685,979,741	8.3	693
North Carolina	161,358	42.7	92,476,204	12.3	573
North Dakota	14,227	35.4	8,136,083	6.7	572
Ohio	574,811	53.3	670,772,480	32.7	1,167
Oklahoma	105,556	43.6	72,725,224	17.2	689
Oregon	75,216	46.3	28,747,065	11.0	382
Pennsylvania	602,751	54.8	344,454,673	17.3	571
Rhode Island	38,170	39.3	15,239,737	5.8	399
South Carolina	161,503	61.6	46,066,557	11.7	285
South Dakota	14,468	39.5	8,431,124	8.2	583

Table B-4.—MEDICAID PAYMENTS FOR DEPENDENT CHILDREN UNDER AGE 21, BY STATE, FISCAL YEAR 1986—Continued

State	Number of dependent children under age 21	Number of dependent children as percent of total beneficiaries	Total payment for dependent children under age 21	Payments for dependent children as percent of total beneficiaries	Payments per dependent child under age 21
Tennessee	168,600	42.7	120,175,691	16.8	713
Texas	369,634	42.1	172,841,411	10.6	468
Utah	34,777	46.0	16,000,495	11.4	460
Vermont	21,384	42.8	8,933,253	9.4	418
Virginia	127,305	40.5	48,725,394	8.2	383
Washington	195,191	54.5	94,070,356	15.0	482
West Virginia	71,770	34.0	28,175,610	14.0	393
Wisconsin	252,606	61.7	88,015,508	9.6	348
Wyoming	8,316	39.6	4,152,813	12.6	499
Total	9,429,352	45.5	5,082,495,570	12.4	539
All Jurisdictions	10,030,673	44.5	5,135,752,591	12.5	512

Source: HCFA-2082 forms.

d. Early and Periodic Screening, Diagnosis, and Treatment Services. One service requirement of particular importance to children is the requirement that States provide Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services to Medicaid eligible children up to age 21. The EPSDT program is designed to assure the availability and accessibility of required health care resources and to help eligible children use them effectively. Under EPSDT, State are required not only to finance services, but also to conduct outreach activities that link Medicaid-eligible children with providers. Each State's Medicaid program must (1) inform all eligible children about EPSDT services, (2) provide screening and diagnostic services, and (3) provide treatment to correct or ameliorate any discovered health problems.

Each State must provide, at a minimum, the following EPSDT services: assessments of health, developmental, and nutritional status; unclothed physical examinations; immunizations appropriate for age and health history; appropriate vision, hearing, and laboratory tests; dental screening furnished by direct referrals to dentists, beginning at age 3; and treatment for vision, hearing, and dental services found necessary by the screening. Each State is required to have a periodicity schedule which meets reasonable standards of medical and dental practice, as determined by the State Medicaid agency after consultation with recognized medical and dental organizations involved in children's health care. The periodicity schedule specifies which screening services would apply to which stage of a child's life.

States are permitted to provide services to children under EPSDT even if they are otherwise not available, or available on a limited basis, to other Medicaid beneficiaries (e.g., vision, hearing, and dental services that may not otherwise be available from that State's Medicaid program).

The ratio of screening examinations per eligible child—and the ratio of screening examinations which have identified referable conditions—vary by age (see table B–5). While the ratio of screening examinations to eligible child under age 6 in FY1987 was 54.3 percent, the ratio for eligible children age 6 to 20 was 13.7 percent. One-quarter of the screening examinations for children under age 6 identified referable conditions, while one-third of the examinations for children age 6 to 20 identified referable conditions. This may, in part, be explained by periodicity schedules which recommend more frequent visits for younger children.

For information on examinations and referrals by State see table B–6. In most States, pediatric providers may receive Medicaid reimbursement for child health examinations, even if they do not meet all of the EPSDT content and frequency requirements, as long as they are performed outside the EPSDT program.[20] As a result, the EPSDT data presented in tables B–5 and B–6 may not reflect all of the Medicaid screening and treatment services provided to children, and may be responsible for some of the variation among States seen in table B–6.

Table B–5.—EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM PARTICIPATION DATA, BY AGE OF CHILD, FISCAL YEAR 1987

Age of child	Number of eligible children [1]	Average number of screening examinations	Screening ratio (percent)	Number with referable conditions	Percent with referable conditions
Total children under age 21	[2] 9,598,314	[3] 2,845,886	29.6	[3] 779,249	27.4
Children under age 6	3,766,172	2,044,824	54.3	511,773	25.0
Children age 6 to 20	5,832,151	798,606	13.7	266,739	33.4

[1] Average of the eligible number of children in each of the 4 quarters of fiscal year 1987.
[2] Sum of age group data does not equal total due to rouding and averaging error.
[3] Sum of age group data does not equal total due to unavailability of age group data from Idaho. There were 2,456 screening examinations and 737 children with referable conditions in Idaho in fiscal year 1987.

Source: HCFA–420 forms. Supplied by Health Care Financing Administration, Office of Medicaid Management.

Table B–6.—EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM PARTICIPATION DATA, BY STATE, FISCAL YEAR 1987

State	Number of eligible children	Number of screening examinations	Sceening ratio (percent)	Number with referable conditions	Percent with referable conditions
National total	9,598,314	2,845,886	29.6	779,249	27.4
Alabama	130,105	38,646	29.7	23,635	61.2
Alaska	12,980	7,036	54.2	1,040	14.8
Arizona	71,348	12,636	17.7	6,387	50.5
Arkansas	77,068	4,853	6.3	1,385	28.5
California	1,664,622	811,349	48.7	219,798	27.1
Colorado	71,367	21,914	30.7	13,776	62.9
Connecticut	84,276	11,186	13.3	3,408	30.5
Delaware	16,563	1,441	8.7	62	4.3
District of Columbia	64,886	15,309	23.6	11,082	72.4
Florida	226,608	115,201	50.8	35,596	30.9

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[20] Rosenbaum, Sara, and Kay Johnson. Providing Health Care for Low-Income Children: Reconciling Child Health Goals With Child Health Financing Realities. The Milbank Quarterly, v. 64, no. 3, 1986. p. 464–465.

Table B–6.—EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM PARTICIPATION DATA, BY STATE, FISCAL YEAR 1987—Continued

State	Number of eligible children	Number of screening examinations	Sceening ratio (percent)	Number with referable conditions	Percent with referable conditions
Georgia	219,675	79,477	36.2	50,902	64.0
Guam	3,715	462	12.4	101	21.9
Hawaii	38,890	8,173	21.0	266	3.3
Idaho	15,402	2,456	15.9	737	30.0
Illinois	628,116	188,211	30.0	24,550	13.0
Indiana	136,766	10,011	7.3	3,353	33.5
Iowa	91,617	9,792	10.7	942	9.6
Kansas	67,944	21,363	31.4	2,938	13.8
Kentucky	172,512	16,414	9.5	5,045	30.7
Louisiana	210,308	67,375	32.0	36,899	54.8
Maine	46,613	18,927	40.6	2,156	11.4
Maryland	146,203	37,291	25.5	12,756	34.2
Massachusetts	222,352	100,900	45.4	4,283	4.2
Michigan	587,530	121,941	20.8	43,616	35.8
Minnesota	136,204	27,773	20.4	16,657	60.0
Mississippi	177,106	55,405	31.3	9,733	17.6
Missouri	146,250	31,110	21.3	3,442	11.1
Montana	23,625	6,549	27.7	2,335	35.7
Nebraska	41,697	18,954	45.5	4,322	22.8
Nevada	12,130	5,822	48.0	4,808	82.6
New Hampshire	13,787	1,719	12.5	5	0.3
New Jersey	269,725	27,571	10.2	7,860	28.5
New Mexico	49,969	9,281	18.6	1,872	20.2
New York	971,691	132,162	13.6	22,861	17.3
North Carolina	146,076	73,125	50.1	2,651	3.6
North Dakota	15,661	3,603	23.0	2,513	69.7
Ohio	516,198	170,002	32.9	19,552	11.5
Oklahoma	84,374	18,084	21.4	7,794	43.1
Oregon	69,214	14,907	21.5	5,068	34.0
Pennsylvania	488,347	115,794	23.7	61,198	52.9
Puerto Rico	0	0	0.0	0	0.0
Rhode Island	31,450	9,073	28.8	408	4.5
South Carolina	107,573	66,480	61.8	19,866	29.9
South Dakota	15,552	2,553	16.4	701	27.5
Tennessee	173,522	46,151	26.6	14,406	31.2
Texas	372,639	81,355	21.8	35,109	43.2
Utah	38,687	6,023	15.6	3,273	54.3
Vermont	21,121	12,242	58.0	325	2.7
Virgin Islands	7,419	486	6.6	237	48.8
Virginia	146,744	90,359	61.6	2,593	2.9
Washington	173,792	26,043	15.0	6,387	24.5
West Virginia	96,808	51,240	52.9	6,220	12.1
Wisconsin	235,028	18,158	7.7	11,733	64.6
Wyoming	8,459	1,498	17.7	607	40.5

Source: HCFA–420 forms. Supplied by Health Care Financing Administration, Office of Medicaid Management.

B. CHILDREN WITH CHRONIC CONDITIONS

1. PREVALENCE OF CHRONIC CONDITIONS IN CHILDREN

While definitions of chronic conditions vary, most medical experts agree that a chronic condition is one which lasts for a substantial period of time (usually at least 3 months), and in some cases may extend over an entire lifetime.[21]

Estimates of the prevalence of chronic conditions in children range from 10 to 20 million, depending on the definitions used, populations investigated, and methods of study.[22] Most children with chronic conditions have mild conditions, such as mild cases of allergies, asthma, or acne. Many of the children with mild chronic conditions do not require prolonged and expensive medical treatment. Children may outgrow many of these conditions as they mature.

Some children, however, have chronic conditions which regularly limit their daily life activities. Depending on the estimate used, about 1 to 3 million children face some degree of disability as a result of their chronic condition. The level of disability ranges from those children limited in their ability to participate in sports or other recreational activities to those children who are disabled to the extent that they cannot attend school (or cannot engage in ordinary play activities if they are of preschool age).[23]

The following groupings of chronic conditions were identified in a study of 1980 NMCUES data to be the leading reported causes of disability among children: (1) mental disorders and nervous system disorders, including mental retardation, neurotic and personality disorders, epilepsy, and cerebral palsy; (2) respiratory system diseases, primarily asthma; (3) musculoskeletal and connective tissue diseases, including acquired deformities, arthritis, and other joint disorders; and (4) diseases and disorders of the eyes and ears. These conditions accounted for over half of all conditions reported as main causes of activity limitations.[24]

The study also indicates that the risk of disability varies by age and income. Reports of activity limitations were more common among teenagers and young adults than among young children. Disability was also more likely to be reported among poor children than among children from families with higher incomes.

A subset of the chronically disabled child population are those children who must depend on life-sustaining medical technology. The Office of Technology Assessment (OTA) defines a technology-dependent child as "one who needs both a medical device to compensate for the loss of a vital body function and substantial and ongoing nursing care to avert death or further disability." [25]

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[21] Perrin, James M. Introduction. In Hobbs, Nicholas, and James M. Perrin, eds. Issues in the Care of Children with Chronic Illness. San Francisco, Jossey-Bass Publishers, 1985. p. 2.

Fact Book on the Chronically Ill Child Population. In Briefing Memoranda for Meeting on the Feasibility of High Risk Pools to Provide Health Insurance Protection for Children with Special Health Care Needs. Washington, Sponsored by the American Academy of Pediatrics, the Bureau of Maternal and Child Health, the March of Dimes, and the National Association of Insurance Commissioners, Dec. 14 and 15, 1987. p. 2.

[22] Gortmaker, Steven L. and William Sappenfield. Chronic Childhood Disorders: Prevalence and Impact. Pediatric Clinics of North America, v. 31, Feb. 1984. p. 3–4.

Perrin, James M. Chronically Ill Children in America. Caring, v. 4, May 1985. p. 17.

Fact Book on the Chronically Ill Child Population, p. 2–3.

[23] Newacheck, Paul W. The Costs of Caring for Chronically Ill Children. Business and Health, v. 4, Jan. 1987. p. 1-2.

Fact Book on the Chronically Ill Child Population, p. 3–4.

Butler, John A., Sara Rosenbaum, and Judith S. Palfrey. Ensuring Access to Health Care for Children with Disabilities. The New England Journal of Medicine, v. 317, July 16, 1987. p. 163.

Perrin, Introduction, p. 3.

[24] Newacheck, Paul W., and Margaret A. McManus. Financing Health Care for Disabled Children. Pediatrics, v. 81, no. 3, Mar. 1988. p. 387.

[25] U.S. Congress. Office of Technology Assessment. Technology-Dependent Children: Hospital v. Home Care: A Technical Memorandum. Washington, U.S. Govt. Print. Off., May 1987. p. 3.

In its study on technology-dependent children, OTA identified the following four groups of children that might be considered technology-dependent: (1) children dependent at least part of each day on mechanical ventilators; (2) children requiring prolonged intravenous administration of nutritional substances or drugs; (3) children with daily dependence on other device-based respiratory or nutritional support, including tracheostomy tube care, suctioning, oxygen support, or tube feeding; and (4) children with prolonged dependence on other medical devices that compensate for vital body functions who require daily or near daily nursing care (i.e., those who require infant apnea monitors, renal dialysis, or other medical devices and substantial nursing care in connection with their disabilities).

Table B-7 displays OTA estimates for the number of technology-dependent children in each of these groups. The number of children considered to be technology dependent is under 17,000 when limited to the first three categories, but increases significantly when the fourth category (which includes children who are less likely than the others to require long-term hospitalization) is included. The number would increase further if the definition included not only those children dependent on medical devices, but also those who require constant or frequent nursing care because of complex drug or therapy needs.[26]

Table B-7.—SUMMARY OF THE OFFICE OF TECHNOLOGY ASSESSMENT ESTIMATES OF THE SIZE OF THE TECHNOLOGY-DEPENDENT CHILD POPULATION, 1987

Defined population	Estimated number of children
Group 1: Requiring ventilator assistance	680 to 2,000
Group 2:	
Requiring parenteral nutrition	350 to 700
Requiring prolonged intravenous drugs	270 to 8,275
Group 3: Requiring other device-based respiratory or nutritional support	1,000 to 6,000
Group 4:	
Requiring apnea monitoring	6,800 to 45,000
Requiring renal dialysis	1,000 to 6,000
Requiring other device-associated nursing	Unknown, perhaps 30,000 or more

Source: U.S. Congress. Office of Technology Assessment. Technology-Dependent Children: Hospital v. Home Care: A Technical Memorandum. Washington, U.S. Govt. Print. Off., May 1987. p. 4.

2. SERVICES FOR CHILDREN WITH CHRONIC CONDITIONS

Children with chronic conditions may have special needs not only for medical services, but also for psychosocial, educational, family support, and coordination services.

- *Medical services.* Most children with chronic conditions have health care needs that are similar to those of children without chronic conditions. Some children with chronic conditions, however, require additional or more intense health care services than those required by children who are healthy or who have acute illnesses. For the most part, the latter group includes children whose chronic disorders are severe enough to interfere with their daily activities. However, some children with chronic conditions who are not disabled (e.g., certain children with diabetes or hemophilia) require regular primary care services and more frequent hospitalizations for acute illnesses due to their increased risk of infection and serious accident.[27]

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[26] Office of Technology Assessment, Technology-Dependent Children, p. 3–4.

The type of services required by these children may include highly specialized medical and surgical services. The children may also require acute and primary care, both specifically for their chronic disorders and generally for diseases unrelated to them. Preventive services, such as early identification and treatment, are particularly important to children with chronic conditions, and may improve long-term outcomes. Other health service needs of this population include home care services and the services of allied health professionals, such as occupational and physical therapy and nursing care.

- *Psychosocial services.* Some chronically disabled children and their families may require services for psychological and social problems (e.g., mental health services to help the child cope with their condition). Disabled children and their families have an increased risk of such problems (although the size of the increased risk is uncertain). Studies indicate that moderately severe chronic conditions often have a more negative psychosocial impact than either mild or very severe conditions; that is, these studies suggest that it may be easier to adjust to a complete disability than to a partial one. In addition, psychosocial impact may be determined by such factors as the disorder's location and cosmetic effects, the child's age, the socioeconomic status and marital stability of the parents, and the support of friends and relatives.[28]
- *Educational services.* The educational needs of disabled children vary according to the chronic disorder which limits their activity. For example, different services would be called for depending on whether a child is mentally retarded, has a specific learning disability, or is blind or deaf. Children with orthopedic problems may require architectural or structural assistance in order to gain access to schools. Secondary effects of chronic conditions, such as missed school days or depression, may also interfere with learning.[29]
- *Family support services.* The families of children with chronic conditions may require certain support services, such as respite care, support groups, or counseling. The existence of childhood chronic conditions often disrupts family living, by introducing repetitive, demanding, and stressful routines into a family's daily life. For example, urinalysis for children with diabetes, exercise for children with juvenile arthritis, and monitoring for children with autism are required frequently. Parents of

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[27] Fact Book on the Chronically Ill Child Population, p. 6.

Iryes, Henry T. Health Care for Chronically Disabled Children and Their Families. In Better Health for Our Children: A National Strategy. The Report of the Select Panel for the Promotion of Child Health to the United States Congress and the Secretary of Health and Human Services, v. 4. Background Papers. Washington, U.S. Govt. Print. Off., 1981. p. 326.

[28] Iryes, Health Care for Chronically Disabled Children and Their Families, p. 327.

Perrin, James M. Chronically Ill Children: An Overview. Topics in Early Childhood Special Education, v. 5, winter 1986. p. 5.

[29] Iryes, Health Care for Chronically Disabled Children and Their Families, p. 328.

children with limited mobility need to provide them with transportation. In addition, families with children who have chronic disorders need to acquire special knowledge of such matters as preparing special diets and securing financial resources.[30]

- *Coordination of services.* Coordination of services is important to children with chronic disabilities. One approach to coordination is case management; under case management one individual or organization is responsible for locating, coordinating, and monitoring all of the medical, social, and educational services needed by the patient. Disabled children may receive services from a large and diverse group of providers (including family physicians, pediatricians, medical specialists, pediatric nurses, physical therapists, social workers) and support from a variety of institutions (such as hospitals, schools, public health programs, and community organizations). These caregivers may have contradictory values, competing interests, and difficulty in communicating with one another. Without coordination of services, these issues may stand in the way of development of comprehensive health care delivery system for chronically ill children.[31]

3. USE AND COST OF MEDICAL SERVICES BY CHILDREN WITH CHRONIC CONDITIONS

The use of medical care services by children with chronic disorders varies with the type of condition and its severity. On average, children under age 21 with disabling chronic conditions were more than twice as likely to be hospitalized as children without disabilities, according to 1980 NMCUES data.[32] Among hospitalized children, disabled children were likely to have hospital stays which were twice as long as those for other children. As a result, disabled children spent about four times as many days in the hospital as nondisabled children.[33]

Children with activity limitations also used greater levels of outpatient care. Disabled children visited physicians almost twice as often as others.They were over five times more likely to use the services of nonphysician health professionals, such as nurse practitioners, physical therapists, psychologists, and social workers.

Chronically disabled children received twice the number of prescribed medications and twice the number of specified medical items (including vision aids, orthopedic items, hearing aids, diabetic items, and ambulance or medical transportation services).

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[30] Iryes, Health Care for Chronically Disabled Children and Their Families, p. 329–330.

[31] Iryes, Health Care for Chronically Disabled Children and Their Families, p. 334.

[32] The NMCUES data may underestimate the use of health care services by chronically disabled children. Underestimates may occur because the survey is designed to measure the use of health care services by the entire population, not the use of special services by disabled children. As a result, NMCUES data do not include data on the use of certain specialized items and services provided to the disabled and do not measure the care provided in institutions. Another result is that the size of the sample may be too small to detect rare chronic conditions. In addition, because the data were gathered in 1980 and 1981, they do not reflect recent trends in health care financing and delivery. The alternatives to these general national surveys are studies which are limited to States or local areas, or which focus on particular conditions; however, such studies are difficult to make generalizable to broader populations.

[33] Newacheck, The Costs of Caring for Chronically Ill Children, p. 19–20.
Newacheck and McManus, Financing Health Care for Disabled Children, p. 388.

The same NMCUES data were used to estimate health care expenses. On average, health spending for disabled children under age 21 in 1980 was nearly three times as high ($760) as spending for the nondisabled ($263). Of the total $21.9 billion in expenses for children's health services, 11 percent ($2.4 billion) was accounted for by the 4 percent of children who reported activity limitations.[34]

Compared to spending for nondisabled children, spending for disabled children under age 21 was almost three times as high for inpatient hospital services; more than twice as high for physician services; more than six times as high for nonphysician medical professionals; and over twice as high for prescribed medications, and specified medical items (including vision aids, orthopedic items, hearing aids, diabetic items, and ambulance or medical transportation services). In addition, out-of-pocket costs (i.e., those paid directly by the family) were higher for disabled children, even though such costs represented a smaller share of their total expenditures.

Even within the disabled children population, there was a great deal of variation in health care spending. A small proportion of disabled children, primarily those who were hospitalized, accounted for a large share of total spending for disabled children. When ranked by expenditures, the 10 percent of disabled children with the highest per capita costs (those children with costs exceeding $1,800) accounted for 65 percent of total charges; the disabled children ranked in the top quarter of per capita costs accounted for 87 percent of all expenditures. Those disabled children ranked in the bottom half of spending had per capita expenditures below $200, primarily for ambulatory services.[35]

4. MEDICAID SERVICES

Whether a chronically disabled child's health needs are met by Medicaid depends on the benefits offered in that child's State. Some of the Medicaid covered services needed by disabled children are mandated by Federal law, while others are permitted at State option. Among the mandatory services important to chronically disabled children are inpatient and outpatient hospital care, physician services, laboratory and x-ray services, and EPSDT services.

Some of the Medicaid services covered at State option are particularly important to children with chronic disabilities. As of October 1, 1987, most States provided services in intermediate care facilities for the mentally retarded (47 States and the District of Columbia), services in skilled nursing facilities for patients under 21 (46 States and the District of Columbia), prescription drugs (48 States and the District of Columbia), and prosthetic devices (47 States and the District of Columbia). Certain other services important to disabled children, however, are not offered as universally, including physical therapy (not covered in 17 States); occupational therapy (not covered in 26 States); speech, hearing, and language disorder services (not covered in 18 States); and private duty nursing (not covered in 31 States).[36]

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[34] Because NMCUES underestimates health services expenditures for chronically disabled children, the data are better used to gain an understanding of general expenditure trends than to determine exact spending amounts.

[35] Newacheck and McManus, Financing Health Care for Disabled Children, p. 389–390. Newacheck, The Costs of Caring for Chronically Ill Children, p. 22–23.

States are allowed to place certain limits on the amount, duration, and scope of covered services, regardless of whether the services are mandatory or optional. For example, a State Medicaid plan may restrict the number of days, number of visits, length of time, or exact type of service covered. Some of these restrictions, such as annual limits on hospital days, may be significant to the care of chronically disabled children. States may also require prior authorization of certain services in order to control their utilization.[37]

The Medicare Catastrophic Coverage Act of 1988 (Public Law 100–360) provides that State Medicaid plans which impose day limits on payments for inpatient hospital services must establish exceptions to those limits for medically necessary inpatient services for infants (up to age 1) in hospitals which serve a disproportionate share of low-income patients. If a State Medicaid plan pays for inpatient hospital services on a prospective payment basis, it must provide by July 1, 1989, for outlier adjustments to compensate disproportionate share hospitals for infants whose hospital stays are unusually long or costly.[38] These changes have the practical effect of increasing compensation for the treatment of premature infants, infants with acquired immunodeficiency syndrome (AIDs), and other disabled infants in hospitals located in States with Medicaid programs that impose durational limits or currently do not provide "outlier" adjustments.

States also have certain options to expand the Medicaid services available to children. Under the Medicaid EPSDT program, a State may provide services to children even if they are otherwise not available, or available under a limited basis, to other Medicaid beneficiaries (e.g., vision and hearing services may not otherwise be available from the State's Medicaid plan). States also have the option of targeting case management services to specified groups of Medicaid beneficiaries, such as certain children, without being required to offer the same services to all other beneficiaries. Case management services are those designed to improve the access of Medicaid beneficiaries to necessary medical, social, and educational services. Under case management, one individual or organization is responsible for locating, coordinating, and monitoring all of the services needed by the patient. States may target the case management services to a specific geographical area within the State without being required to make services available throughout the State.

If a State elects to provide Medicaid coverage to the medically needy, it may choose, but is not required, to offer the same services as it provides to the categorically needy. States which cover the medically needy, however, must at least provide a minimum level of services to this coverage group, including ambulatory care services for children and home health services to those individuals entitled to skilled nursing facility services. States which elect to cover services in institutions for mental diseases or in intermediate care facilities for the mentally retarded are required to provide a broader range of services to the medically needy.

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[36] U.S. Department of Health and Human Services. Health Care Financing Administration. Office of Intergovernmental Affairs. Medicaid Services State by State. HCFA Pub. No. 02155–88. Oct. 1, 1987. For a list of Medicaid services covered by State Medicaid plans, see table III–2.

Butler, John A., Peter Budetti, Margaret A. McManus, Suzanne Stenmark, and Paul W. Newacheck. Health Care Expenditures for Children with Chronic Illnesses. In Hobbs, Nicholas, and James M. Perrin, eds. Issues in the Care of Children with Chronic Illness. San Francisco, Jossey-Bass Publishers, 1985. p. 848.

[37] Fox, Harriette B., with Ruth Yoshpe. Medicaid Financing for Early Intervention Services. Washington, Fox Health Policy Consultants, June 1987. p. 23.

Butler, et al., Health Care Expenditures for Children with Chronic Illnesses, p. 848.

[38] For a more detailed explanation of disproportionate share hospitals, see chapter IV.

II. FINANCING HEALTH CARE FOR CHILDREN

A. Health Insurance Coverage of Children

1. EXTENT OF HEALTH INSURANCE COVERAGE

Four-fifths (80.9 percent) of all children under age 18 were estimated to have some form of health insurance coverage (including Medicaid coverage) in 1986, leaving about one-fifth (19.1 percent) with no insurance source, according to data from the March 1987 Current Population Survey (CPS).[39] The percentage of children covered by health insurance was slightly lower than the percentage of the general population. Of the total population, the percentage with health insurance coverage was 85 percent; of the nonaged, about 83 percent were covered.

Though most children do have health insurance, concern remains about those who lack this protection. As discussed previously, uninsured children have lower levels of medical care use than children with private or public health insurance coverage—uninsured low-income children are more likely to have gone without a medical visit in the previous year and are more likely to have seen a physician less frequently than an insured child.[40] In addition, uninsured children expose their families to the risk of extremely high health care expenses. Under certain circumstances, however, children with such expenses may become eligible for Medicaid (i.e., if the child requires institutional care or if the family's medical expenses reduce their income below the Medicaid income thresholds) or free or discounted medical care (i.e., through public grants, philanthropy, or medical providers).[41]

2. SOURCES OF INSURANCE

Private health insurance (including parents' employment-based health insurance plans and those policies purchased directly by families) represent the largest source of health insurance for children. In 1986, 66.2 percent of children under age 21 were reported to be covered by such plans, according to CPS data.

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[39] These Congressional Research Services estimates are based on data obtained from the March 1987 Current Population Survey (CPS) conducted by the Bureau of the Census. Because the estimates are based on a sample, they may differ somewhat from the figures that would have been obtained if a complete census had been taken. CPS may also underestimate private health insurance coverage of those children who are covered through a noncustodial parent. No adjustments have been made for underreporting of insurance. While these considerations must be taken into account, general trends can be observed from the data.

[40] Butler, et al., Medical Care Use and Expenditure Among Children and Youth in the United States, p. 498–499.

Rosenbach, Insurance Coverage and Ambulatory Medical Care of Low-Income Children, p. 15.

Davis, Karen and Diane Rowland. Uninsured and Underserved: Inequities in Health Care in the United States. Milbank Memorial Fund Quarterly/Health and Society, v. 61, no. 2, 1983. p. 159–170.

[41] Office of Technology Assessment, Healthy Children, p. 58–59.

The second most important source of health coverage was the Medicaid program, which covered 12.8 percent of children. Some children were covered by other public health insurance plans such as Medicare and military health plans. Other children were covered by a combination of public and private health insurance.

Medicaid coverage of children is targeted to certain low-income children, including all recipients of public assistance from the Aid to Families with Dependent Children (AFDC) program, most recipients of public assistance from the Supplemental Security Income (SSI) program (which assists the low-income aged, blind, and disabled), and members of other specified groups (such as certain other pregnant women and children).

Medicaid is also targeted to certain children with high medical expenses who would be eligible except that their family income and resources are just above the eligibility limits.

Because Medicaid is targeted to specific groups, the program's role in financing health care for children becomes more clear when family income level and health status are taken into account.

3. FAMILY INCOME AND HEALTH INSURANCE COVERAGE

The role of Medicaid in financing health care for children can be made clear by an examination of family income. More poor children (i.e., those with family incomes below 100 percent of the Federal poverty level) under age 18 (51.8 percent) are covered by Medicaid than by any other source of health insurance (see figure B-3 and table B-8). This is due, in part, to Medicaid eligibility rules which target Medicaid to specified groups, including certain poor children.

However, low family income does not guarantee Medicaid coverage (see appendix A). Roughly one-third (32.8 percent) of all poor children have no private or public insurance coverage. Figure B-3 and table B-8 also show that children from families with incomes below Federal poverty guidelines, as well as children from families with incomes between 100 percent and 150 percent of Federal poverty guidelines, were less likely to have health coverage than children from more affluent families. According to the CPS data, although children from families with incomes below 150 percent of Federal poverty guidelines account for 31.1 percent of the population under age 18, they comprise 53.8 percent of uninsured children under age 18.[42]

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[42] Unpublished data from the Current Population Survey, March 1987 Income Supplement.

Table B-8.—HEALTH INSURANCE STATUS OF CHILDREN UNDER AGE 18, BY INCOME LEVEL, 1986

Health insurance status	Family income level as a percentage of the Federal poverty level				Total
	Less than 100 percent	100 to 150 percent	150 to 200 percent	More than 200 percent	
	Share (percent) with insurance coverage				
Medicaid only	47.9	9.6	4.1	0.7	11.7
Medicaid and other insurance [1]	3.9	4.0	2.3	0.5	1.8
Other insurance only	15.3	53.1	69.4	88.2	67.5
No insurance	32.8	33.4	24.2	11.0	19.1

[1] The Current Population Survey does not ask questions about dual health insurance coverage. Individuals who responded that they were covered by more than one form of health insurance may either have had dual coverage or different forms of coverage at different times of the year.

Source: Current Population Survey, March 1987 Income Supplement.

4. HEALTH STATUS AND HEALTH INSURANCE COVERAGE

While many of the health insurance issues that apply to primary care coverage also apply to the coverage of children with chronic conditions, certain issues are of particular interest due to the high health care costs which families of chronically disabled children may face.

Disabled children have roughly the same rate of health insurance coverage as other children; however, they are less likely to be covered by private health insurance plans and more likely to be covered by Medicaid or other public plans. Data from the 1984 National Health Interview Survey show that 61.7 percent of children under age 18 with activity limitations had private insurance coverage only, compared to 71.3 percent of children without limitations. In contrast, 21.4 percent of the disabled had public coverage only, while 12.5 percent of the nondisabled had such coverage. Four percent of the disabled and 1.7 percent of the nondisabled were covered by a combination of both public and private coverage. The remaining 12.9 percent of the disabled and 14.5 percent of the nondisabled were uninsured.[43]

Among the explanations that have been offered for the differences in private and public coverage are: unavailability of individual coverage for children with severe disabilities, lack of coverage above maximum lifetime limits, policies which exclude coverage of preexisting conditions, mandatory waiting periods before coverage may take effect, and parental decisions to rely on government programs for health coverage.[44]

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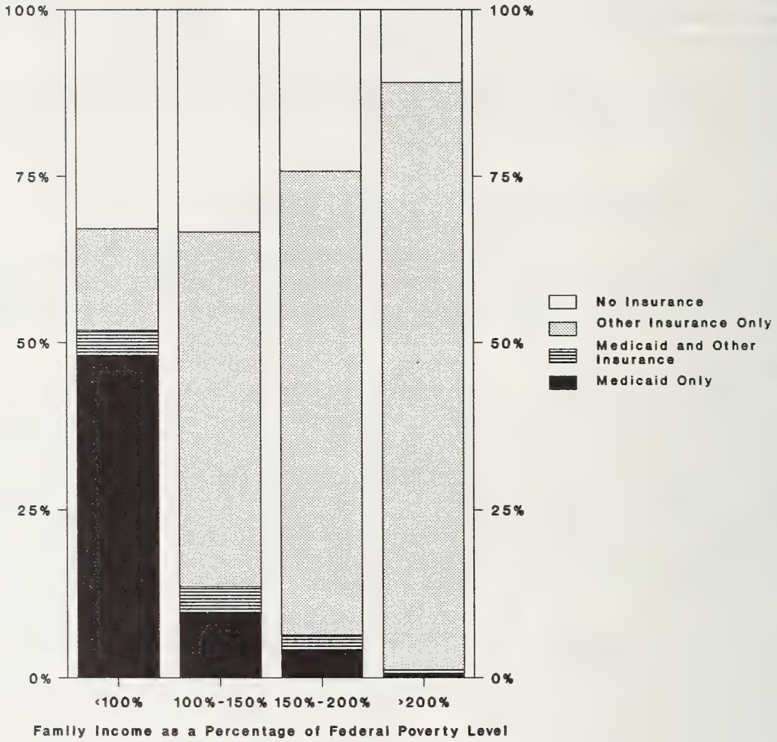
[43] Fact Book on Chronically Ill Children's Insurance in the Current Health Care Insurance Market. In Briefing Memoranda for Meeting on the Feasibility of High Risk Pools to Provide Health Insurance Protection for Children with Special Health Care Needs. Washington, Sponsored by the American Academy of Pediatrics, the Bureau of Maternal and Child Health, the March of Dimes, and the National Association of Insurance Commissioners, Dec. 14 and 15, 1987. p. 4.

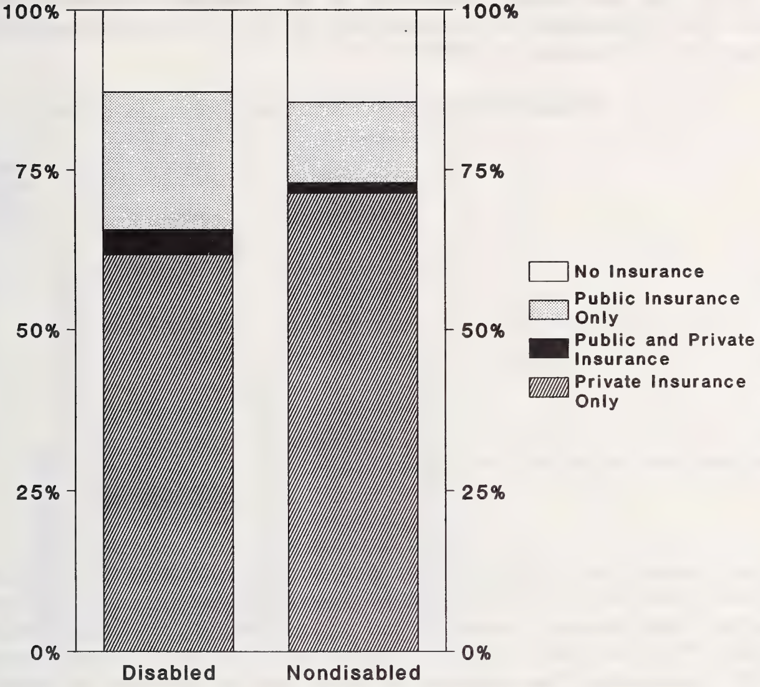
[44] Office of Technology Assessment, Technology-Dependent Children, p. 52.

Figure B-3
Health Insurance Status of Children Under Age 18, By Family Income Level, 1986



Source: Current Population Survey, March 1987 Income Supplement.

Figure B-4
Health Insurance Status of Disabled and Nondisabled Children Under Age 18, 1984



Source: 1984 National Health Interview Survey.

B. Medicaid and Poor Children

1. MEDICAID COVERAGE OF POOR CHILDREN

Roughly one-half of all poor children are covered by Medicaid, according to CPS estimates. Of the 12.9 million children under age 18 estimated to be in poverty in 1986, 6.7 million were covered. Figure B–5 and table B–9 show that the percentage of covered poor children was 48.5 percent in 1979. After a decrease to 46.5 percent in 1981, the percentage returned to 48.5 percent in 1983. Since then, the percentage of covered poor children has continually increased to 51.8 percent in 1986.[45]

Table B–9.—MEDICAID COVERAGE OF POOR CHILDREN UNDER AGE 18, 1979–86

Year	Number of poor children (in thousands)	Number of poor children with Medicaid coverage (in thousands)	Percentage of poor children with Medicaid coverage
1979	10,111	4,907	48.5
1980	11,764	5,525	47.0
1981	12,505	5,811	46.5
1982	13,647	6,429	47.1
1983	13,807	6,693	48.5
1984	13,419	6,622	49.3
1985	13,010	6,569	50.5
1986	12,876	6,676	51.8

Source: Current Population Survey, Annual March Income Supplements.

2. THE WELFARE LINK

One reason that the share of poor children covered by Medicaid has not been larger in the past is that Medicaid eligibility of such children has generally been linked to the receipt of AFDC cash assistance.[46] This has restricted Medicaid coverage in part because AFDC assistance has generally been available only to families where the child is deprived of the support of at least one parent (i.e., at least one parent is dead, disabled, continually absent from the home, or, in some States, unemployed).[47] To receive AFDC benefits, families have also been required to meet income eligibility standards established by each State; because these standards may have been below Federal poverty guidelines, many poor families

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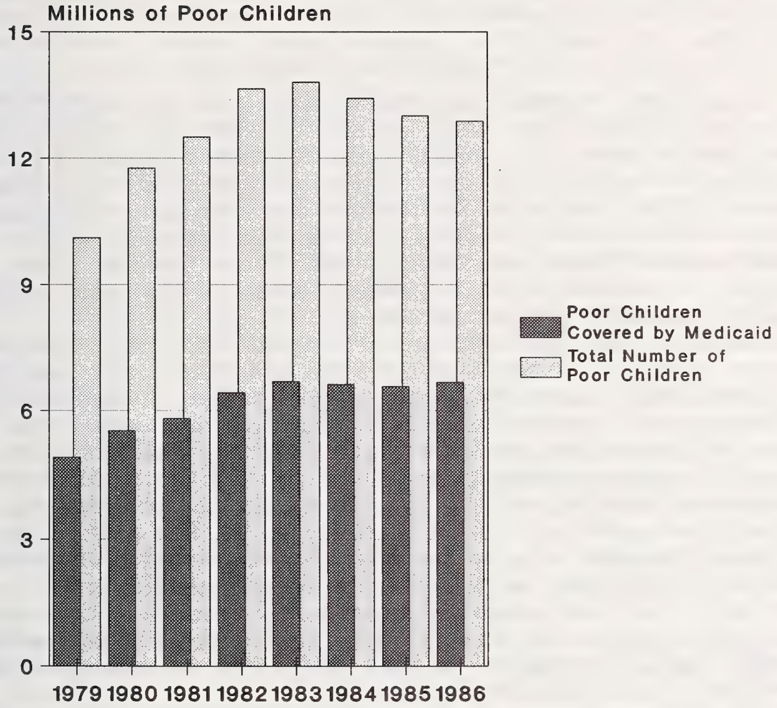
[45] These Congressional Research Service estimates of Medicaid coverage of poor children are based on CPS data collected annually by the Bureau of the Census. Because the estimates are based on a sample, they may differ somewhat from the figures that would have been obtained if a complete census had been taken. CPS data on Medicaid are lower than program data from HCFA because beneficiaries tend to underreport their benefits in these surveys. Respondents may also underreport their sources and amounts of income. Poverty status is based on total cash income, including welfare income; Medicaid eligibility is based on income prior to receipt of welfare benefits. The CPS totals do not include children in institutions. While these considerations must be taken into account, general trends can be observed from the data.

[46] For a complete description of Medicaid eligibility, see chapter II.

[47] The States, however, have had the option to extend Medicaid coverage to certain other children, including those known as "Ribicoff children," whose family income and resources are at or below the State's AFDC limit, but who do not meet the AFDC definition of dependent children.

Figure B-5
Number of Poor Children Under Age 18 Covered By Medicaid, 1979-1986



Source: Current Population Survey, Annual March Income Supplements. Figure prepared by Congressional Research Service, Education and Public Welfare Division.

with dependent children have not been automatically eligible for Medicaid.[48]

Legislation enacted in 1981 may have denied AFDC assistance, and consequently automatic Medicaid coverage, to some poor children and their families.[49] Some of these children were able to regain Medicaid protection in those States with medically needy programs; the reduction in the number of eligible children may have also been offset in 1982 by an increase in the number of children who became eligible for AFDC and Medicaid when a recession cut their family incomes.

3. DISCONNECTING THE LINK

Since 1984, Congress has acted to disconnect the eligibility link between Medicaid and cash welfare for some poor children and pregnant women. As a result, States are now required to provide Medicaid coverage to certain children and pregnant women ineligible for AFDC. In addition, States have also been given the option to cover certain other groups of children and pregnant women and still receive Federal matching funds. These expansions are designed to promote access to prenatal care and the other primary health care services described above.

Congress made these changes in response to, among other concerns, trends in indicators of maternal and child health status, including infant mortality. After a long period of declining U.S. infant mortality rates, Federal officials expressed concern that the pace of this decline was slowing. This slowing decline caused concern for several reasons. Infant mortality rates are one of the most commonly used indicators of a population's health status, and are closely associated with life expectancy levels. The pace of the decline left in doubt whether the nation would meet the U.S. Surgeon General's 1990 goal for reducing the infant mortality rate; it was unlikely that the Surgeon General's goal of reducing the infant mortality rate for all racial or ethnic groups would be achieved. Finally, the U.S. continued to have high levels of infant mortality relative to other industrialized nations.[50]

In addition to interest in improving health status, Congress also expanded Medicaid eligibility in order to support the work efforts of AFDC mothers. Medicaid coverage may present AFDC beneficiaries with work disincentives because Medicaid benefits—coverage of medical expenses—are not varied by income. Because many of those who leave the AFDC rolls lose their automatic eligibility for Medicaid, the extra wage dollar that lifts a family over the AFDC eligibility limit may cause the loss of significant health benefits that are not available from the employer. The value of the medical benefits may put nonworking AFDC beneficiaries in a better financial position than working families.[51]

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[48] Some of these children, however, may have been able to obtain coverage through State medically needy programs. The medically needy are those individuals with high medical expenses who would qualify for Medicaid except that their family income and resources are just above the eligibility limits.

See appendix A for more information on how Medicaid eligibility can vary by State, family structure, and work status.

[49] The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) ended AFDC eligibility for some families with a working parent by treating earnings less liberally and imposing a Federal gross income limit. The result was that some working poor families were removed from AFDC.

See U.S. General Accounting Office, Report to the Chairman, Select Committee on Aging, House of Representatives. Medicare and Medicaid: Effects of Recent Legislation on Program and Beneficiary Costs. GAO/HRD-87-53.

[50] Griffith and Cislowski, Infant Mortality, p. 12.

4. MEDICAID ELIGIBILITY EXPANSIONS

As a result of the recent expansion of Medicaid eligibility, all individuals in the following groups are entitled to Medicaid, provided their income and resources fall within State AFDC limits, regardless of family structure or employment status:

- Pregnant women, from medical verification of pregnancy through the month which includes the 60th day postpartum;
- Children born on or after October 1, 1983, up to age 7;
- Former AFDC beneficiaries who lost cash eligibility after 4 months in a job because of the legal requirement that more earnings then be used to offset the AFDC benefit. These beneficiaries are entitled to Medicaid for 9 months after loss of AFDC eligibility, and at State option, for an additional 6 months (previously enacted laws grant some short-term coverage in cases of increased earnings or work hours).

States also have the option to extend Medicaid protection to, and receive Federal matching funds for, the following groups of individuals:

- Children up to age 21 whose family income and resources are at or below the State's AFDC limit, but who do not meet the AFDC definition of dependent children, such as many poor children in two-parent families (States are required to cover these children up to age 7, if they are born on or after October 1, 1983);
- Pregnant women and children born on or after October 1, 1983, up to age 8, whose family incomes are at or below 100 percent of Federal poverty guidelines;
- Pregnant women and children up to age 1 whose family incomes are at or below 185 percent of Federal poverty guidelines.[52]

The Medicare Catastrophic Coverage Act of 1988 (Public Law 100–360) mandated Medicaid coverage for certain pregnant women and infants (i.e., children under age 1) whose coverage was previously optional with the States. Effective July 1, 1989, States will be required to cover all pregnant women and infants, regardless of family composition, with incomes below 75 percent of the Federal poverty guidelines. Effective July 1, 1990, States will be required to cover those with incomes below 100 percent of the Federal poverty guidelines.

In addition, States have been recently given the option to offer short-term Medicaid eligibility, known as "presumptive eligibility," to pregnant women so that they can receive ambulatory prenatal care services while their Medicaid applications are processed, if a qualified provider determines that a pregnant woman's family income is below State eligibility thresholds.[53]

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[51] Cislowski, Joseph A. Current Welfare System: Expanded Medical Care. Congressional Research Service Review, July 1987. p. 8.

[52] For a more precise overview of Medicaid eligibility for the coverage groups listed above, see the eligibility discussion found in chapter II.

5. STATE RESPONSES TO COVERAGE OPTIONS

Federal law requires the States to extend Medicaid eligibility to some of the groups of pregnant women and children described above; however, in other cases, the States have the choice of whether to include particular groups. For example, the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509, commonly referred to as OBRA86) allows States to extend eligibility to pregnant women—and, on a phased-in basis, young children born on or after October 1, 1983—whose family incomes are at or below 100 percent of Federal poverty guidelines. OBRA86 also allows States to offer short-term presumptive eligibility to certain pregnant women who are waiting for their Medicaid applications to be processed.

Table B–10 shows that, as of January 1988, 24 States and the District of Columbia have elected to cover pregnant women and children up to 100 percent of the poverty guidelines, according to the National Governors' Association. Washington State covers these groups up to 90 percent of the poverty guidelines. California did not exercise this option because it already covers these groups within its medically needy income threshold, set at 109.7 percent of the poverty level. Minnesota raised its medically needy threshold, and now covers pregnant women and children up to 91.5 percent of the poverty guidelines.

As of January 1988, 12 States have adopted the presumptive eligibility option, according to the National Governors' Association. These States are also listed in table B–10.

Table B–10.—STATE RESPONSES TO OBRA86 COVERAGE OPTIONS FOR PREGNANT WOMEN AND CHILDREN, AS OF JANUARY 1988

State	Coverage of pregnant women and children up to specified percentage of poverty	Coverage to age		Presumptive eligibility option	Effective date
		1	2		
Arizona	100		X		1/88
Arkansas	[1] 75/100	X		X	4/87
California	(2)				
Connecticut	100	X		X	[3] 4/88
Delaware	100	X			1/88
District of Columbia		100	X		4/87
Florida	100		X	X	10/87
Kentucky	100		X		10/87
Maine				X	
Maryland	100	X		X	7/87
Massachusetts	100	X		X	7/87
Michigan	100		X		1/88
Minnesota	(4)				
Mississippi	100		X		10/87
Missouri	100		X		1/88
New Jersey	100		X	X	7/87
New Mexico	100		X		1/88

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[53] For more detailed information on presumptive eligibility requirements, see chapter VI.

Table B-10.—STATE RESPONSES TO OBRA86 COVERAGE OPTIONS FOR PREGNANT WOMEN AND CHILDREN, AS OF JANUARY 1988—Continued

State	Coverage of pregnant women and children up to specified percentage of poverty	Coverage to age		Presumptive eligibility option	Effective date
		1	2		
New York				X	
North Carolina	100		X	X	10/87
Ohio	100	X			1/89
Oklahoma	100		X		1/88
Oregon	[1] 85/100		X		11/87
Pennsylvania	100		X	X	[3] 4/88
Rhode Island	100		X		4/87
South Carolina	100	X			10/87
Tennessee	100		X	X	7/87
Utah	100		X	X	[3] 4/88
Vermont	100		X		10/87
Washington	90		X		7/87
West Virginia	100		X		7/87
Total	26	5	21	12	

[1] These States reported that they will increase their income thresholds to 100 percent of poverty during 1988.

[2] California already covers pregnant women (and all other groups) with family incomes below the Federal poverty guideline by virtue of its medically needy threshold.

[3] Projected implementation date.

[4] In response to OBRA86, Minnesota elected to raise its medically needy threshold to the highest possible percentage (133 1/3 percent) of AFDC payment standards and, as a result now covers all pregnant women with family incomes up to 91.5 percent of the Federal poverty guideline.

Source: National Governors' Association.

Another eligibility rule of interest to a narrower group of pregnant women and children is the exemption of those pregnant women and children under age 18 who are aliens participating in the alien legalization process from a 5-year prohibition of Medicaid coverage which would otherwise apply to those seeking permanent residence status. In addition, all aliens must be covered for emergency services (including delivery services), regardless of their immigration status, if they would otherwise meet Medicaid requirements.

The HHS Secretary may waive certain Medicaid program requirements as necessary in order to conduct demonstration projects. For example, the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203, commonly referred to as OBRA87) specifically authorizes the Secretary to waive specified program requirements in order to conduct a 3-year demonstration of New York State's prenatal, maternity, and newborn care pilot program as an alternative to existing Federal programs. The Secretary is required to evaluate the project and report to Congress within 1 year of its completion.

C. Medicaid and Disabled Children

Medicaid can be a major source of health care financing for chronically disabled children who are poor, but only if the children and their families meet their State's Medicaid eligibility standards. Poor children with activity limitations are more likely to be covered under Medicaid than poor children without any limitations. According to National Health Interview Survey data from 1983 and

1984, 58.7 percent of poor disabled children had Medicaid coverage, while 43.7 percent of poor nondisabled children were covered.[54]

1. MEDICAID ELIGIBILITY

As described in chapter II, those eligible for Medicaid include all recipients of public assistance from the AFDC program, most recipients of public assistance from the SSI program (which assists the low-income aged, blind, and disabled), and members of other specified groups (such as certain other pregnant women and children). In order to be eligible, individuals must meet not only categorical requirements, but also income and resource requirements.

Medicaid allows the States to extend eligibility to medically needy children—those children with high medical expenses who would qualify for Medicaid except that their family income and resources are above the eligibility limits. Families with incomes higher than the medically needy limits may become eligible by "spending down," if their medical expenses reduce their incomes below the medically needy limits, and they meet assets tests.

Some disabled children may not qualify for Medicaid, even under medically needy provisions, because the income and resources of their parents are "deemed" to be available to them if they are living in the same household.

Because children receiving institutional care (e.g., care in a hospital, skilled nursing facility, or intermediate care facility) are not considered to be living in their parents' household after the first month of institutionalization, family income and resources are not considered in determining eligibility after the first month.

Because of Medicaid eligibility rules, some disabled children not otherwise eligible for Medicaid may become eligible while institutionalized. Until recently, however, such children rarely would have been eligible for equivalent care at home, even if their medical needs could have been appropriately provided there. The following provisions of Medicaid law now allow States to expand eligibility and increase covered services for the provision of home care to disabled children:[55]

- *Regular Section 2176 waivers.* Section 2176 of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) allows States to request waivers of selected Federal requirements in order to provide home and community-based services to certain Medicaid beneficiaries who would otherwise require care in an institution.[56] Under the Section 2176 waivers, States may select targeted populations (i.e., those in specified groups or in specified areas) which would then be subject to broader income eligibility rules and an expanded range of home and community based services (including some services, not primarily medical in nature, which allow these patients to be cared for at home). Among the groups which may be covered under Section 2176 waivers are (1) the aged and disabled, (2) the mentally retarded and developmentally disabled, and (3) the chronically mentally ill. In order to gain approval for the waiver, States must demonstrate that, on an average per capita basis, the costs of the home and community based services will not exceed the cost of institutional care;

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[54] Newacheck, Paul W. Unpublished data from the National Health Interview Survey, 1983 and 1984 combined annual averages.

[55] U.S. Library of Congress. Congressional Research Service. Medicaid "2176" Waivers for Home and Community-Based Care. Report No. 85-817 EPW, by Carol O'Shaughnessy and Richard Price. Washington, 1985. p. 1-5, 16-17.

Office of Technology Assessment, Technology-Dependent Children, p. 62-64.

[56] The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) and the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) clarified that Section 2176 waivers applied to ventilator-dependent and other patients who would otherwise require hospital-level care.

- *Model Section 2176 waivers for the disabled.* HCFA created a separate category of Section 2176 waivers, known as model waivers, to enable States to provide home and community based services to certain disabled children and adults who would otherwise be eligible for Medicaid only if institutionalized. This may occur as a result of SSI income eligibility rules (i.e., those which would prevent patients living at home from receiving SSI because family income and resources are deemed to be available to them). The Secretary of Health and Human Services may not limit each model waiver to fewer than 200 blind or disabled individuals who would otherwise be ineligible for Medicaid while living at home because of these SSI deeming rules. States may only cover under the waiver those eligible individuals whose estimated home care costs do not exceed their estimated institutional costs;
- *Optional eligibility for disabled children.* In addition to the waiver options, States also have the option to extend Medicaid eligibility to certain disabled children who would otherwise be eligible only if they lived in an institution. The State must determine that these children require the level of long-term care provided in an institution, and that their needs can be met appropriately and at no greater cost at home. Under this provision, only the usual Medicaid services can be offered to these children; that is, special services cannot be extended to only this coverage group. If the State does make this option available to any disabled children, it must allow all children meeting the eligibility criteria to participate, regardless of whether or not they have been institutionalized.

The Medicare Catastrophic Coverage Act of 1988 (Public Law 100–360) established a new waiver program for children known as "boarder babies." These children—who test positive for the human immunodeficiency virus (HIV), are infected with the acquired immunodeficiency syndrome (AIDS), or who are drug dependent at birth—often may remain in hospitals indefinitely because of problems in finding alternative placement. Such children up to age 5 may become eligible for this new Section 1915(e) waiver if they (1) are receiving or are expected to receive federally funded adoption or foster care assistance, and (2) would be likely, in the absence of services provided under the waiver, to require the level of care provided by a hospital or nursing facility.[57]

Another eligibility rule important to chronically disabled children is the one which requires States to extend Medicaid eligibility to certain children for whom Federal adoption assistance or foster care maintenance payments are made under Title IV–E of the Social Security Act. Children receiving Federal adoption assistance are those identified as having special needs, such as those related to a disability. States have the option to cover certain children for whom State adoption assistance payments are made if the child is identified as having special needs. States often provide Medicaid coverage and other benefits to these disabled children as an incentive for families to care for them.

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[57] For more information on this population see appendix H. For more information on the 1915(e) waiver, see chapter V.

D. Other Sources of Financing Care

1. OTHER FEDERAL PROGRAMS

There are many other Federal health programs which have a significant effect on the health of children. These include the Maternal and Child Health Services Block Grant, Childhood Immunization program; the Community Health Center program; the Family Planning program; the National Institute of Child Health and Human Development; the Alcohol, Drug Abuse, and Mental Health Block Grant; the Preventive Health and Health Services Block Grant; the Indian Health program; the Migrant Health program; the grant program for certain health services for the homeless; Medicare's End-Stage Renal Disease program; the Federal Employees Health Benefits program, and various military health care programs.

In addition, even though they are not strictly characterized as health programs, certain other Federal programs (e.g., those intended to improve nutrition or to provide services to the developmentally disabled) also have an important impact on the health of children.

This appendix does not contain information on these other programs; however, Federal Programs Affecting Children (CRS Report No. 87–306 EPW) does provide detailed descriptions of health, income, nutrition, social service, education, housing, and tax programs of particular relevance to children.

2. VOLUNTARY INITIATIVES

Although the financial support provided by charitable organizations do not constitute a large share of health care expenditures for children with chronic conditions, these organizations have carved out a specialized financing role. They often focus their activities on one condition or on a group of related conditions. Their activities may include support for biomedical research, promotion of public education (including advocacy), and the direct provision of services and patient education to children and their families. The services provided by charitable organizations often include those that are not usually otherwise reimbursable by other financing sources.[58]

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[58] Butler et al., Health Care Expenditures for Children with Chronic Illnesses, p. 844–845.

APPENDIX C. MEDICAID, THE ELDERLY, AND LONG-TERM CARE [1]

SUMMARY

Medicaid serves a diverse elderly population. This diversity results, in part, from eligibility policies that determine who can be covered. By far the largest group of elderly persons covered under Medicaid is the cash categorically needy group. These are persons who become eligible for Medicaid by virtue of their having income low enough to qualify for cash welfare assistance (e.g., Supplemental Security Income (SSI)). The cash categorically needy represent 54 percent of elderly Medicaid beneficiaries. However, payments made on their behalf amounted to only 25 percent of total program payments for the aged.

The noncash categorically needy and the medically needy accounted for the remaining 75 percent of Medicaid payments for the elderly. These persons are not poor by cash welfare program standards. An analysis of spending for these two eligibility groups shows that these individuals include many persons who use nursing home care. Nursing home payments for these two groups together amounted to 58 percent of total Medicaid payments for all services for all elderly beneficiaries. Many noncash categorically needy beneficiaries become eligible for Medicaid because they require nursing home care and the States in which they reside use a higher income standard for nursing home residents. The medically needy include many persons who deplete their resources and income on the cost of nursing home care. With nursing home care costing in the range of $22,000 a year, many elderly persons in nursing homes quickly meet the resources and income requirements for Medicaid coverage of their care.

Medicaid spending for nursing home care, especially for these two groups of elderly beneficiaries who do not receive cash assistance, reflects the lack of alternative insurance protection for this care. Medicare, the Federal health insurance program for the elderly and disabled, has only very limited coverage for nursing home care, both in terms of the days of care that are covered and the conditions under which a person may qualify for the benefit. This continues to be the case after the recent enactment of the Medicare Catastrophic Coverage Act of 1988, Public Law 100–360. Private insurance coverage is also limited at this time. As a result, Medicaid has become the Nation's major program of financial support for persons needing nursing home care. The only other major source of funding for nursing home care is not a formal program of support or coverage, but rather private out-of-pocket payments individuals and families make for the cost of care. Private out-of-pocket payments amounted to 51 percent of total national spending for nursing home care in 1986.

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[1] This chapter was written by Richard Price.

While Medicaid will pay for nursing home care for many persons who are not poor enough to qualify for cash welfare assistance, rules—both for determining eligibility and for the treatment of income following eligibility—have had important implications for spouses who were left in the community with little income and assets of their own. These rules have often resulted in the impoverishment of the spouse remaining in the community. Provisions in Public Law 100–360 addressed these "spousal impoverishment" issues.

These same rules governing eligibility, and the treatment of income following eligibility, have an impact on an individual's interest and ability to receive home and community-based services under a 2176 waiver program. Under a 2176 waiver program, States may cover a broad range of home and community-based services for persons who would otherwise be eligible for nursing home care or other institutional care under the State's Medicaid plan. However, Medicaid rules may leave the individual with insufficient income and resources to meet basic maintenance expenses required in the community.

In 1987, Congress enacted legislation that addressed various quality issues in nursing home care paid for by Medicaid. The legislation, included as part of Omnibus Budget Reconciliation Act of 1987 (OBRA87), Public Law 100–203, comprehensively reforms provisions in Medicaid law applying to nursing homes participating in Medicaid. The legislation includes (1) changes in the standards of care nursing homes must meet in order to participate; (2) measures to strengthen the survey process for determining whether nursing homes are complying with these standards; and (3) new remedies for sanctioning noncompliant nursing homes.

This appendix discusses these summary findings in greater depth. First, the appendix examines Medicaid payments for the elderly by various categories of covered services and also by eligibility status. This analysis reveals that Medicaid serves a diverse elderly population and that Medicaid payments for this group of beneficiaries are driven both by program coverage of nursing home care and by coverage of elderly persons who are not initially poor, according to cash welfare program standards. The appendix next discusses this spend-down process for persons needing nursing home care as well as issues related to requirements persons must meet in order to have Medicaid pay for their care. Similar issues are discussed in the context of 2176 waiver programs that allow States to cover home and community-based services for persons who would otherwise require nursing home care. The appendix concludes with a brief discussion of legislation enacted in 1987 to improve the quality of care provided by nursing homes participating in Medicaid.

I. PATTERNS OF MEDICAID PAYMENTS FOR AGED MEDICAID BENEFICIARIES

A. MEDICAID PAYMENTS FOR AGED AND NONAGED BENEFICIARIES, BY CATEGORY OF SERVICE

Over the years, elderly Medicaid beneficiaries have accounted for a disproportionately large portion of Medicaid payments for services. In 1972, elderly beneficiaries represented 19 percent of total program beneficiaries and accounted for 38 percent of program payments. While the aged have declined as a proportion of total program beneficiaries since that time, their proportion of total program payments has remained relatively constant. In fiscal year 1986, aged beneficiaries represented 14 percent of total Medicaid beneficiaries and their share of program payments amounted to 37 percent of total program payments.

In fiscal year 1986, total Medicaid payments for all services used by the elderly (e.g., hospital, physician, prescription drugs, as well as home health and nursing home care) amounted to $15.1 billion. Table C–1 shows fiscal year 1986 Medicaid payments for elderly beneficiaries, and the percentage distribution of these payments by category of service.[2] Of total payments for the elderly, payments for nursing home care (i.e., intermediate care facility (ICF) and skilled nursing facility (SNF) care) accounted for by far the greatest portion.[3] In fiscal year 1986, ICF and SNF payments amounted to two-thirds of total payments made for services for the elderly. Other major categories of payments for aged beneficiaries include inpatient hospital services (10.6 percent), prescription drugs (6.4 percent), and home health services (5.1 percent).

Table C–1 also provides data on Medicaid payments for nonelderly beneficiaries by category of service. The distribution of payments for services for aged beneficiaries differed significantly from the distribution of payments for nonaged beneficiaries. For nonaged beneficiaries, inpatient hospital services accounted for the largest portion of program payments. These payments amounted to nearly 34 percent of total payments. Physician services followed, amounting to nearly 9 percent of the total. ICF and SNF care together amounted to slightly more than 9 percent of total payments for nonaged beneficiaries. Nursing home payments were seven times as large a share of total payments for aged beneficiaries as they were for nonaged beneficiaries. Almost 20 percent of program payments for the nonaged were made for ICF care for the mentally retarded (ICF/MR). These are discussed in appendix D. Figure C–1 illustrates the differences in the distribution of Medicaid payments for aged and nonaged beneficiaries, by selected service categories.

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[2] Medicaid covered services vary from State to State. In addition, States may place limitations on the amount, duration, and scope of covered services. See chapter III for details.

[3] Medicaid law defines SNF services as services which are required to be given to an individual who needs, on a daily basis, skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services which, as a practical matter, can only be provided in a SNF on an inpatient basis.

Medicaid law defines an ICF as an institution that is licensed under State law to provide on a regular basis health-related care and services to individuals who do not require the degree of care and treatment which a hospital or SNF is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be provided only through institutional facilities.

Effective Oct. 1, 1990, Public Law 100–203, the Omnibus Budget Reconciliation Act of 1987, will eliminate Medicaid's distinction between SNFs and ICFs, and will create in their place a "nursing facility" benefit.

Table C–1.—MEDICAID VENDOR PAYMENTS FOR THE AGED AND NONAGED, BY SERVICE TYPE, FISCAL YEAR 1986

	Total		Aged		Nonaged	
	Amount	Percent of total	Amount	Percent of total	Amount	Percent of total
Total	41,027,283	100.0	15,099,800	100.0	25,927,483	100.0
ICF	6,780,258	16.5	5,583,041	37.0	1,197,217	4.6
SNF	5,655,667	13.8	4,475,639	29.6	1,180,028	4.6
Inpatient Hospital Services	10,369,811	25.3	1,603,665	10.6	8,766,145	33.8
Inpatient Mental Health	1,111,163	2.7	694,246	4.6	416,917	1.6
ICF/MR	5,081,366	12.4	179,487	1.2	4,901,879	18.9
Physician Services	2,548,208	6.2	264,516	1.8	2,283,692	8.8
Dental Services	531,852	1.3	37,241	0.2	494,610	1.9
Other Practitioner Services	251,587	0.6	38,525	0.3	213,062	0.8
Outpatient Hospital Services	1,982,875	4.8	126,258	0.8	1,856,617	7.2
Home Health	1,352,106	3.3	766,140	5.1	585,966	2.3
Lab and X-ray	424,394	1.0	30,968	0.2	393,426	1.5
Prescribed Drugs	2,691,874	6.6	972,621	6.4	1,719,253	6.6
Other Care	2,246,123	5.5	327,451	2.2	1,918,672	7.4

Note: Payment amounts are for all jurisdictions. Breakout is based on eligibility status.
Source: HCFA form 2082.

The difference in the distribution of payments for services for aged and nonaged beneficiaries is in part the result of elderly individuals needing and using nursing home care more often than younger age groups. The 1985 National Nursing Home Survey found that of the total number of persons residing in nursing homes at the time of the survey, 88 percent were 65 years of age and older. Nearly 84 percent of these elderly persons were 75 years of age and older.

The different pattern in payments for services for elderly and nonelderly beneficiaries also reflects the fact that most elderly Medicaid beneficiaries are covered under the Medicare program as well. For these dually eligible individuals, Medicare is the primary payer for those services it covers in common with Medicaid. Medicare therefore commonly pays for inpatient hospital and physician services instead of Medicaid, with the result that Medicaid as a source of payments for these services will be comparatively less important for elderly beneficiaries than for nonelderly Medicaid beneficiaries.[4]

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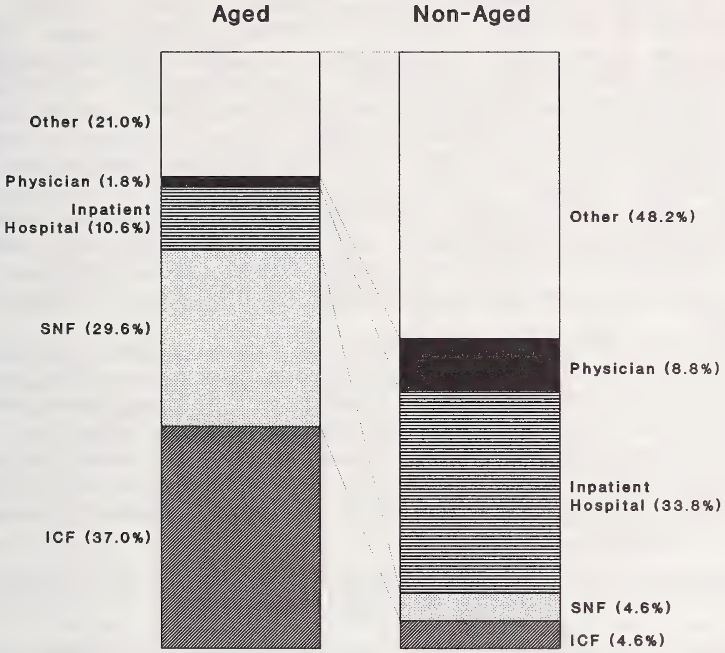
[4] The Medicare Catastrophic Coverage Act of 1988, Public Law 100–360, may change this pattern of payment somewhat as new Medicare benefits are phased in for dually eligible beneficiaries. For example, this new law eliminates, effective January 1, 1989, the day limits, coinsurance charges, and spell of illness provisions pertaining to Medicare's hospital benefit. To the extent that Medicaid incurred payments for hospital care as the result of these provisions, payments for hospital care will be reduced because Medicare will now be responsible for these costs. The catastrophic legislation also establishes a maximum out-of-pocket limit on beneficiary cost sharing charges for covered Part B services. Beginning in 1990, Medicare will pay 100 percent of recognized charges in full above this limit (set at $1370 for 1990), and Medicaid will no longer be responsible for paying them for dually eligible beneficiaries. In addition, effective January 1, 1990, Medicare will begin to cover certain home intravenous drugs and immunosuppressive drugs, and, effective January 1, 1991, outpatient prescription drugs. Both benefits will be subject to deductibles and coinsurance charges. To the extent Medicare will begin to cover costs that had been previously paid for exclusively by Medicaid, Medicaid payments will be reduced for this category of service.

Figure C-1
Allocation of Medicaid Payments By Service Category for Aged and Non-Aged Beneficiaries, FY 1986



Source: HCFA-2082 forms. Figure prepared by Congressional Research Service, Education and Public Welfare Division.

The specific benefits covered by Medicare also explain why Medicaid payments for services such as nursing home care are as important as they are. Medicare's coverage is focused primarily on acute health care, particularly hospital and physician care and accompanying periods of recovery. The program was never envisioned to provide protection for the long-term care needs of a chronically impaired elderly population. Many chronically impaired elderly persons require assistance with certain basic self-care functions such as bathing, dressing, eating, toileting, and/or mobility from one place to another. The 1985 National Nursing Home Survey found that most elderly nursing home residents required assistance with these basic self-care functions, often referred to as activities of daily living. Medicare will not cover nursing home care for persons who need this level of assistance only. Rather, Medicare's coverage is limited to short-term stays in SNFs for those persons who can demonstrate a need for daily skilled nursing care. Many persons who require long-term nursing home care do not need daily skilled nursing care and therefore do not qualify for Medicare's benefit. The Medicare Catastrophic Coverage Act of 1988, Public Law 100–360, did not change this requirement for Medicare's nursing home benefit.

Medicaid, however, covers this level of nursing home care. Medicaid has become the Nation's major program of coverage for nursing home care. In 1986, Medicaid spending for nursing home care (including SNF, ICF, and ICF/MR) amounted to 41 percent of total national spending for nursing home care, and 87 percent of public spending for this care. By way of contrast, Medicare's expenditures for nursing home care amounted to less than 2 percent of total national spending.

B. Medicaid Payments for Aged Beneficiaries, by Eligibility Status

Elderly individuals become eligible for Medicaid benefits in one of three ways: (1) as categorically needy individuals who receive cash assistance (e.g., SSI); (2) as optional categorically needy individuals who do not receive cash assistance but who meet certain other criteria, such as residing in a nursing home and having income below a certain specified level; and (3) as medically needy individuals who incur medical expenses that reduce their income and/or resources to certain levels specified by the State (see chapter II). These different paths to eligibility result in Medicaid serving a diverse elderly population.

Figure C–2 shows the number of aged Medicaid beneficiaries in each of these three eligibility categories and payments made on their behalf. A total of 3.1 million aged persons received Medicaid benefits in fiscal year 1986. By far the largest group of aged Medicaid beneficiaries is the cash categorically needy. These are persons whose incomes are low enough to qualify them for cash welfare assistance. Cash categorically needy aged beneficiaries amounted to 54 percent of aged beneficiaries, or almost 1.7 million persons. The remainder of the population was split into two groups.

Twenty-three percent, or approximately 728,000 persons, were eligible as optional categorical needy individuals who do not receive cash assistance. Elderly noncash categorical needy individuals include many persons who require long-term care services, particularly nursing home care, and also home and community-based care. These noncash categorical needy individuals needing long-term care often become eligible for Medicaid according to special income rules used by certain States for persons residing in nursing homes or in need of home and community-based care provided under 2176 waiver programs. By Federal law, this special level can be no more than 3 times the basic SSI payment level, and is often referred to as the "300 percent rule."

Medically needy elderly beneficiaries accounted for another 23 percent of total aged Medicaid beneficiaries, or approximately 732,000 persons. These beneficiaries also include many persons who require long-term care services, and particularly nursing home care. The average cost of nursing home care is in the range of $22,000 per year.[5] This very large expense enables many elderly persons whose incomes are high enough for them to be considered part of the middle class to qualify for Medicaid coverage of their care through the "spend-down" process.[6]

Figure C–2 also indicates each of these three groups' associated share of payments. While the categorically needy aged represented 54 percent of total aged beneficiaries, payments made on their behalf amounted to only 25 percent of total program payments for the aged. Proportionately larger payments were made for the noncash categorically needy and for the medically needy. The 23 percent of aged beneficiaries who were noncash categorically needy accounted for 33 percent of payments for the elderly. The medically needy who represented another 23 percent of aged beneficiaries accounted for 42 percent of program payments for the elderly.

Payments for nursing home care explain much of this disparity. Parts A and B of table C–2 indicate that comparatively larger numbers of noncash categorically needy and medically needy aged individuals used ICF and SNF services than did the categorically needy who receive cash welfare payments. Approximately 8 of every 10 noncash categorically needy and 6 of every 10 medically needy beneficiaries used nursing home care (ICF and SNF) in fiscal year 1986, as opposed to the nearly 1 of every 10 cash categorically needy who used such care in that year. In addition, for all three eligibility categories, nursing home services had high payment costs per beneficiary, as compared to other service categories.

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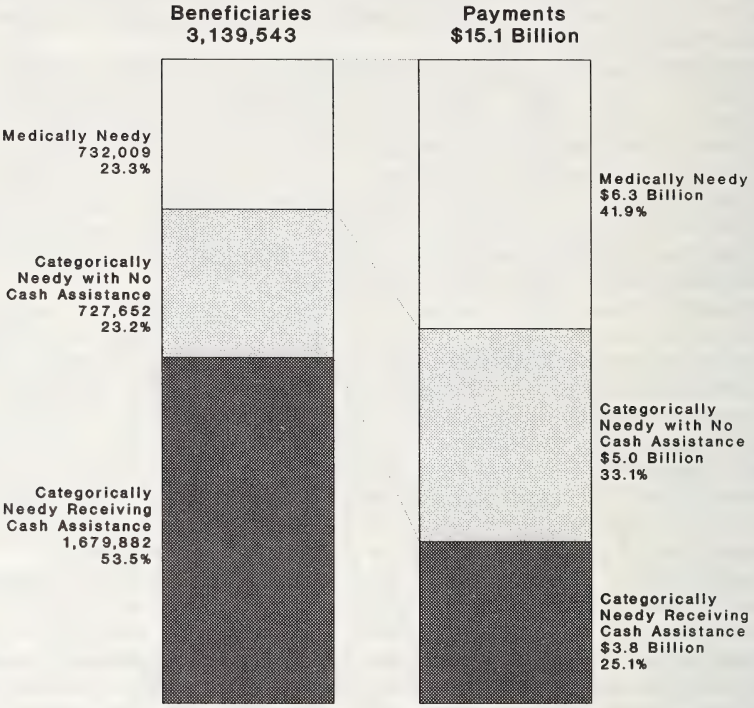
[5] U.S. Department of Health and Human Services. Report to Congress and the Secretary by the Task Force on Long-Term Health Care Policies. Sept. 21, 1987. p. 69.

[6] See chapter II for an explanation of "spend-down."

Figure C-2
Aged Beneficiaries and Payments for Aged Beneficiaries By Eligibility Status, FY 1986



Source: HCFA-2082 forms. Figure prepared by Congressional Research Service, Education and Public Welfare Division.

Table C–2.—SERVICE PAYMENTS PER BENEFICIARY AND NUMBER OF BENEFICIARIES BY SERVICE CATEGORY AND ELIGIBILITY STATUS FOR THE AGED, FISCAL YEAR 1986

	Categorically needy	Categorically needy noncash	Medically needy
A. NUMBER OF BENEFICIARIES IN EACH SERVICE CATEGORY BY ELIGIBILITY STATUS			
ICF	92,592	397,360	223,368
SNF	73,030	170,609	227,969
Inpatient hospital services	412,580	150,238	158,955
ICF/MR	2,715	1,741	1,057
Physician services	1,285,036	477,048	457,488
Dental services	161,582	73,186	93,294
Other practitioner services	374,130	137,072	202,992
Outpatient hospital services	557,311	177,738	150,469
Home health services	152,649	29,345	72,151
Lab and X-ray	557,890	154,096	180,841
Prescribed drugs	1,417,294	599,978	452,114
Other	592,121	293,568	267,297
Total number of beneficiaries	1,679,882	727,652	732,009
B. SERVICE PAYMENTS PER BENEFICIARY BY ELIGIBILITY STATUS			
ICF	8,171	7,635	7,966
SNF	8,037	6,981	11,821
Inpatient hospital services	1,776	859	4,640
ICF/MR	32,520	22,033	46,969
Physician services	125	111	118
Dental services	127	88	109
Other practitioner services	60	47	48
Outpatient hospital services	151	116	142
Home health services	2,623	929	4,692
Lab and X-ray	37	36	26
Prescribed drugs	360	458	418
Other	308	243	275
All services	2,252	6,837	8,647

Source: HCFA form 2082.

In addition, as table C–3 indicates, these two factors together (the large number of nursing home beneficiaries and high payment costs per beneficiary for this care) result in ICF and SNF payments representing a much higher proportion of total payments for the noncash categorically needy and medically needy than for the categorically needy receiving cash benefits. For the noncash categorically needy, ICF and SNF payments combined amounted to 85 percent of total payments for these aged beneficiaries. For the medically needy, ICF and SNF payments amounted to nearly 71 percent of total payments for this group. ICF and SNF payments for the noncash categorically needy and medically needy together amounted to 58 percent of total Medicaid payments for all services for all elderly beneficiaries. ICF and SNF payments for the categorically needy receiving cash, on the other hand, represented only 35.5 percent of total payments for aged beneficiaries in this group. It can also be noted from table C–3 that medically needy beneficiaries have significantly higher expenditures for inpatient hospital care and home health services than do the noncash categorically needy.

Table C–3.—PAYMENTS FOR THE AGED BY SERVICE CATEGORY AND ELIGIBILITY STATUS, FISCAL YEAR 1986

	Categorically Needy				Medically needy		Total	
	Receiving cash		Not receiving cash					
	Payments in millions	Percent of total	Payments in millions	Percent of total	Payments in millions	Percent of total	Payments in millions	Percent of total
Total	$3,784.9	100.0	$4,993.4	100.0	$6,321.5	100.0	$15,099.8	100.0
ICF	755.3	20.0	3,048.3	61.0	1,779.4	28.1	5,583.0	37.0
SNF	587.8	15.5	1,193.1	23.9	2,694.8	42.6	4,475.6	29.6
Inpatient Hospital Services	736.0	19.4	130.5	2.6	737.2	11.7	1,603.7	10.6
Inpatient Mental Health	217.0	5.7	117.6	2.4	359.8	5.7	694.2	4.6
ICF–MR	89.8	2.4	40.0	0.8	49.6	0.8	179.5	1.2
Physician Services	158.5	4.2	52.1	1.0	53.9	0.9	264.5	1.8
Dental Services	20.6	0.5	6.4	0.1	10.2	0.2	37.2	0.2
Other Practitioner Services	22.4	0.6	6.4	0.1	9.7	0.2	38.5	0.3
Outpatient Hospital Services	84.3	2.2	20.6	0.4	21.4	0.3	126.3	0.8
Home Health Services	400.4	10.6	27.2	0.5	338.5	5.4	766.1	5.1
Lab and X-ray	20.8	0.5	5.5	0.1	4.7	0.1	31.0	0.2
Prescribed Drugs	509.5	13.5	274.5	5.5	188.6	3.0	972.6	6.4
Other Care	182.6	4.8	71.0	1.4	73.6	1.2	327.4	2.2

Source: HCFA form 2082.

C. MEDICAID PAYMENTS FOR AGED BENEFICIARIES, BY STATE

As noted above, elderly Medicaid beneficiaries account for a disproportionately large share of Medicaid payments for services. In fiscal year 1986, the elderly represented 14 percent of total program beneficiaries and accounted for 37 percent of program payments. This general pattern of spending for aged beneficiaries exists in each of the States, as table C–4 illustrates. However, there is a good deal of variation among the States, not only in terms of the proportion of beneficiaries who are elderly and the proportion of program payments made on their behalf, but also in the magnitude of the difference between these two ratios. The percentage of aged Medicaid beneficiaries in a State's Medicaid program ranged from 7.6 percent in Illinois to 34.9 percent in Kansas. The proportion of total program payments for aged beneficiaries ranged from 21.5 percent in Illinois to 54.3 percent in New Hampshire. Average payments per aged beneficiary ranged from $1,942 in Alabama to $11,303 in New York. In Kansas, the proportion of program payments for elderly beneficiaries more closely corresponded to their proportion of the beneficiary population (40.4 percent of all payments for 34.9 percent of the beneficiary population). In the District of Columbia, on the other hand, the elderly represented about 10 percent of total beneficiaries and accounted for 40.7 percent of program payments. These variations among the States can be explained by differences in the scope of benefits covered, reimbursement rates for benefits, and eligibility policies for coverage. For example, States that have medically needy programs covering nursing home care for elderly persons will bring into their Medicaid programs large numbers of persons who use services with high payment costs per beneficiary.

Table C–4.—STATE-BY-STATE COMPARISON OF NUMBER OF AGED MEDICAID BENEFICIARIES AND PAYMENTS FOR THESE BENEFICIARIES, FISCAL YEAR 1986

State	Number of aged beneficiaries	Percent of all beneficiarties	Payments for aged beneficiaries	Percent of all payments	Payment per aged beneficiary
Alabama	82,221	26.0	$159,676,471	39.0	$1,942
Alaska	2,593	9.0	22,946,332	27.0	8,849
Arkansas	51,002	25.1	142,946,391	32.9	2,803
California	469,860	13.6	1,043,642,158	23.7	2,221
Colorado	30,189	20.3	113,164,003	37.7	3,749
Connecticut	35,563	16.4	333,093,084	49.3	9,366
Delaware	5,405	13.8	32,551,023	41.2	6,022
District of Columbia	9,729	9.9	81,848,795	40.7	8,413
Florida	115,023	19.6	435,986,817	43.5	3,790
Georgia	92,322	19.1	257,496,161	31.5	2,789
Hawaii	11,055	12.4	58,210,767	42.6	5,266
Idaho	6,087	15.1	31,784,039	37.2	5,222
Illinois	80,963	7.6	359,460,564	21.5	4,440
Indiana	44,154	14.8	299,756,689	36.2	6,789
Iowa	30,785	13.9	113,328,241	30.3	3,681
Kansas	45,787	34.9	96,285,308	40.4	2,103
Kentucky	54,127	13.0	153,908,953	28.7	2,843
Louisiana	92,164	20.6	273,559,839	35.1	2,968
Maine	20,833	16.7	120,605,391	42.7	5,789
Maryland	42,737	13.2	247,814,152	36.4	5,799
Massachusetts	103,427	19.6	687,664,389	41.3	6,649
Michigan	95,708	8.5	402,303,980	22.8	4,203
Minnesota	56,912	16.5	450,932,245	43.2	7,923
Mississippi	62,564	19.6	125,972,614	39.8	2,014
Missouri	64,036	17.8	250,887,521	45.1	3,918
Montana	6,658	12.8	41,933,930	37.4	6,298
Nebraska	15,627	15.3	73,764,847	39.3	4,720
Nevada	6,105	18.8	25,894,692	32.7	4,242
New Hampshire	8,393	23.7	72,302,644	54.3	8,615
New Jersey	66,124	11.4	467,761,706	36.5	7,074
New Mexico	12,253	13.3	44,377,211	26.9	3,622
New York	353,387	15.2	3,994,293,432	48.6	11,303
North Carolina	67,445	17.8	268,368,098	35.7	3,979
North Dakota	9,266	23.1	57,816,157	47.5	6,240
Ohio	94,679	8.8	599,396,436	29.2	6,331
Oklahoma	54,496	22.5	161,963,544	38.4	2,972
Oregon	18,214	11.2	83,990,209	32.3	4,611
Pennsylvania	123,664	11.2	729,934,338	36.6	5,903
Rhode Island	19,053	19.6	119,932,914	45.7	6,295
South Carolina	45,705	17.4	120,589,903	30.6	2,638
South Dakota	7,971	21.7	43,952,114	42.7	5,514
Tennessee	72,126	18.3	226,676,705	31.7	3,143
Texas	213,305	24.3	656,994,954	40.3	3,085
Utah	7,913	10.5	33,780,559	24.1	4,269
Vermont	7,454	14.9	35,549,443	37.6	4,769
Virginia	57,566	18.3	250,825,630	42.2	4,357
Washington	42,275	11.8	204,676,477	32.7	4,842
West Virginia	35,668	16.9	78,331,389	39.0	2,196
Wisconsin	85,243	20.8	394,134,685	42.9	4,624
Wyoming	2,877	13.7	16,237,122	49.5	5,644

Table C-4.—STATE-BY-STATE COMPARISON OF NUMBER OF AGED MEDICAID BENEFICIARIES AND PAYMENTS FOR THESE BENEFICIARIES, FISCAL YEAR 1986—Continued

State	Number of aged beneficiaries	Percent of all beneficiarties	Payments for aged beneficiaries	Percent of all payments	Payment per aged beneficiary
Puerto Rico	0	0.0	0	0.0	
Virgin Islands	1,152	8.3	494,975	12.1	430
U.S. Total (no territories)	3,138,713	15.2	15,099,305,066	36.9	4,811
U.S. Total (with territories)	3,138,865	13.9	15,099,800,041	36.8	4,810

Note: Classification of beneficiaries is based on eligibility status.
Source: Estimates based on data contained in HCFA form 2082.

II. MEDICAID AND LONG-TERM CARE

A. SPENDING DOWN FOR MEDICAID COVERAGE OF NURSING HOME CARE

Medicaid is the Nation's major program of financial support for persons needing nursing home care. It is so because there is no other public or private program that provides comprehensive coverage for long-term nursing home care and because the cost of this care exceeds the income and assets of most elderly persons. In 1986, Medicaid spending for nursing home care (including SNF, ICF, and ICF/MR) amounted to 41 percent of total national spending, and 87 percent of public spending for nursing home care. The other major source of funding for nursing home care is not a formal program of support or coverage, but rather private out-of-pocket payments individuals and families make for the cost of care. Private out-of-pocket payments amounted to 51 percent of total national spending for nursing home care in 1986. Because of its restrictive criteria for coverage of nursing home care, Medicare payments amounted to less than 2 percent of total spending in 1986. Because of limited coverage for long-term nursing home care under private insurance policies, private insurance payments amounted to less than 1 percent. Figure C-3 illustrates the relative shares of public program and private sources of nursing home expenditures for the Nation as a whole in 1986.

Medicaid spending for nursing home care is driven by coverage of elderly beneficiaries who do not receive cash welfare payments—the medically needy and the noncash categorically needy:

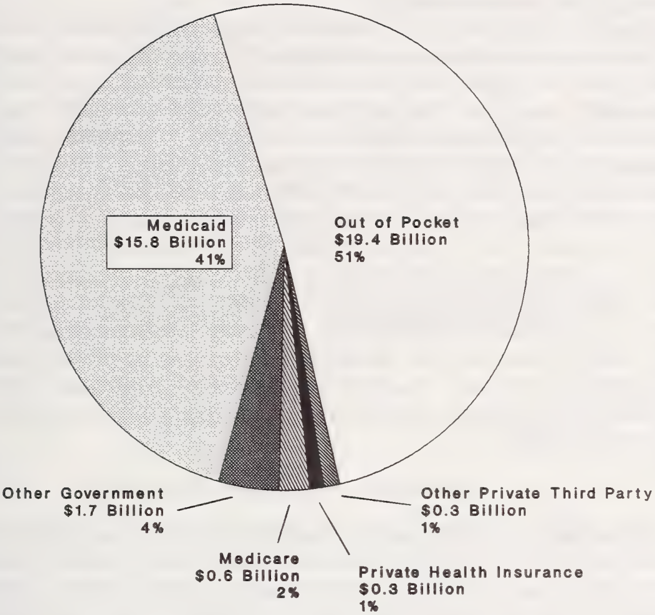
1. MEDICALLY NEEDY

In those States with medically needy programs, the medically needy who qualify for Medicaid payment of their nursing home costs are not initially poor, according to cash welfare program standards. Rather they spend-down their resources and income on the cost of their care to levels that make them eligible for Medicaid coverage in their States. Although the amount of this spend-down can not be quantified, it accounts for some portion of the out-of-pocket payment share of total national spending for nursing home care.

Spending down to become eligible for Medicaid's nursing home benefit is a two-step process: First, persons must meet the re-

Figure C-3
Sources of Funds for Nursing Home Care, 1986

Total $38.1 Billion



Source: Health Care Financing Administration, Office of the Actuary, Division of National Cost Estimates.

sources or assets test.[7] The term "resources" generally refers to liquid assets such as cash on hand, savings and checking accounts, stocks, bonds, etc., as well as real and personal property. In order to be eligible for Medicaid, the value of the individual's available resources must be less than a State-determined dollar standard, usually $1,900 for an individual without a spouse, the level used for the SSI program. For couples, resources must generally be less than $2,850. It should be noted that in determining resources countable for Medicaid eligibility, certain items are excluded under SSI rules and Medicaid rules in almost all States. These exclusions are detailed in chapter II.

Second, after an individual has depleted virtually all accumulated resources on the cost of nursing home care, or has transferred resources (for less than fair market value) prior to the time when eligibility could be denied because of the transfer,[8] income standards are then considered. These income standards vary across the States. Most States (30) have no absolute upper limit on income for applicants residing in nursing homes. See the first column of table C–5 for those States having medically needy programs or those 209(b) States which are required to have spend-down programs because of their more restrictive eligibility policies. In these States with spend-down programs, as long as the applicant's current monthly income is insufficient to cover medical expenses, including the cost of care in the nursing home, the applicant is eligible for Medicaid. However, income in excess of amounts that are disregarded for personal needs and other purposes must be applied to the cost of care.

2. NONCASH CATEGORICALLY NEEDY

A number of States have established a special income level to determine eligibility for persons residing in nursing homes (or in need of home and community-based care). These persons are referred to as noncash categorically needy, and like the medically needy, have income in excess of cash welfare program standards. By Federal law, the special income level used by States can be no more than 3 times the basic SSI payment level (the 300 percent rule). The second and third columns of table C–5 show these special income levels in effect in 1987. Note that several States with medically needy programs also use a special income standard. This enables States to avoid the complex spend-down computation necessary under medically needy programs and to make automatically eligible those persons with incomes below the specified level.

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[7] This discussion on eligibility rules for nursing home care closely follows material contained in: U.S. Library of Congress. Congressional Research Service. Medicaid Eligibility for the Elderly in Need of Long Term Care. CRS Report for Congress No. 87–986 EPW, by Edward Neuschler with the assistance of Claire Gill. CRS Report prepared under Contract no. 86–26 with National Governors' Association. Center for Policy Research. Health Policy Studies. Washington, Sept. 1987. (Hereafter cited as Medicaid Eligibility for the Elderly in Need of Long Term Care)

[8] Prior to the enactment of the Medicare Catastrophic Coverage Act of 1988, Public Law 100–360, States had the option of denying Medicaid eligibility for persons who had transferred resources for less than fair market value. Eligibility could be denied for a period of time if resources had been transferred for less than full market value during a period, generally 24 months, immediately prior to application for Medicaid. Public Law 100–360 establishes a new national transfer of assets policy that States are required to enforce. This policy, effective July 1, 1988, applies only to institutionalized individuals who have disposed of resources for less than fair market value within the 30-month period preceding application for benefits. See chapter II for additional details.

For those States which use only the special income level to determine eligibility, however, elderly persons with incomes above these levels cannot qualify for Medicaid assistance for the cost of their care, no matter what the costs of their care. In addition, these limits in some States are low, especially when compared to the cost of nursing home care. In States using the special income standard, nursing home residents with pension income or veterans benefits may have income too high to qualify for Medicaid coverage of the cost of their nursing home care, even if this income is insufficient to cover the costs of their care. Depending on the particular State and circumstances of the individual, persons whose incomes are too high to allow them to qualify for Medicaid coverage of their nursing home care but too low to pay for the cost of their care might end up either remaining in the community, or relying on family members to pay the balance of the cost of their care. Alternatively, they might find a nursing home willing to accept available income as payment in full, or be referred to other State or local assistance programs or State-owned nursing homes.[9]

Table C–5.—AGED NURSING HOME RESIDENTS WHOSE INCOME EXCEEDS CASH ASSISTANCE LEVELS CAN BE ELIGIBLE FOR MEDICAID (AS OF THE SECOND QUARTER OF 1987)

State	As "medically needy"	Under a special income standard, as follows	
		Monthly gross income must be less than	And/or monthly net income must be less than
Alabama	N/A	$852.90	
Alaska	N/A	1,020.00	
Arkansas	NO	1,020.00	
California	MN-only		
Colorado	N/A	1,020.00	
Connecticut	MN-only		
Delaware	N/A	632.00	
District of Columbia	MN-only		
Florida	NO		$881.00
Georgia	N/A		937.00
Hawaii	MN-only		
Idaho	N/A	1,020.00	
Illinois	MN-only		
Indiana	MR SD-only	1,020.00	
Iowa	NO	1,020.00	
Kansas	MN-only		
Kentucky	MN	1,020.00	
Louisiana	NO	1,020.00	
Maine	MN	1,020.00	NH rate
Maryland	MN-only		
Massachusetts	MN-only		
Michigan	MN-only		
Minnesota	MN-only		
Mississippi	N/A	1,020.00	
Missouri	MR SD-only		

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[9] Conversations with Medicaid officials in Delaware, New Jersey, Oklahoma, South Carolina, Texas, and Virginia.

Table C–5.—AGED NURSING HOME RESIDENTS WHOSE INCOME EXCEEDS CASH ASSISTANCE LEVELS CAN BE ELIGIBLE FOR MEDICAID (AS OF THE SECOND QUARTER OF 1987)—Continued

State	As "medically needy"	Under a special income standard, as follows	
		Monthly gross income must be less than	And/or monthly net income must be less than
Montana	MN-only		
Nebraska	MN-only		
Nevada	N/A	734.00	
New Hampshire	MN	859.00	NH rate
New Jersey	NO	1,020.00	
New Mexico	N/A	871.00	
New York	MN-only		
North Carolina	MN-only		
North Dakota	MN-only		
Ohio	MR SD-only		
Oklahoma	NO	1,020.00	
Oregon	MN	1,020.00	
Pennsylvania	MN	1,020.00	
Rhode Island	MN	1,020.00	
South Carolina	N/A	1,020.00	
South Dakota	N/A	1,020.00	
Tennessee	NO	1,020.00	NH rate
Texas	N/A	658.85	
Utah	MN-only		
Vermont	MN	1,020.00	
Virginia	MN	1,020.00	
Washington	MN	1,020.00	
West Virginia	MN	1,020.00	
Wisconsin	MN-only		
Wyoming	N/A	1,020.00	

Gross Income: The State applies a special income standard to gross income before any deductions, such as the SSI general disregard, are made.

Net Income: The State applies a special income standard to income after standard deductions, usually the SSI general disregard, are made.

MN: The State covers medically needy aged and does cover nursing homes cost for those who qualify as medically needy.

MN-only: Nursing homes residents who do not qualify for a cash payment are covered as only medically needy; a special income level is not used.

MR SD-only: The State does not have a regular medically needy program. Nursing home residents who do not qualify for a cash payment are covered [only] under the "spend-down" process the State is required to implement because it uses Medicaid eligibility rules more restrictive than those used by SSI. These States are commonly referred to as 209(b) States.

N/A: The State does not cover any aged applicants as medically needy, whether or not they reside in a nursing home.

NO: The State has a medically needy program that covers the elderly but nursing home care is not a covered service under that program. In these States, nursing home residents whose income exceeds the level shown in the second or third column cannot have any portion of their routine nursing home care paid for by Medicaid; however, they will probably be eligible for Medicaid coverage of all other services as medically needy.

NH Rate: Nursing home rate.

Source: U.S. Library of Congress. Congressional Research Service. Medicaid Eligibility for the Elderly in Need of Long Term Care. CRS Report for Congress No. 87–986 EPW, by Edward Neuschler. September 1987. Center for Policy Research, National Governors' Association. Prepared under contract No. 86–20. p. 124–125.

B. Medicaid Eligibility Policies as They Affect Institutionalized Elderly Persons with Spouses Still Living at Home

Observers have pointed out that Medicaid rules—both for determining eligibility and for the treatment of income following eligibility—have imposed hardships on certain couples when one spouse needed nursing home care and the other remained in the community. There has been concern that these rules could actually impoverish the spouse remaining in the community because the resources and income allowed to be retained by the community spouse were inadequate to cover basic living expenses and personal needs. Provisions in the Medicare Catastrophic Coverage Act of

1988, Public Law 100–360, addressed these "spousal impoverishment" issues by permitting, effective September 30, 1989, the spouse remaining in the community to retain more resources and income than previously has been allowed.

According to a 1987 survey of the National Governors' Association (NGA), at least 31 States followed SSI's policy of considering joint bank accounts, a commonly held joint resource for the elderly, to be fully available to the applicant for the cost of nursing home care because the applicant could gain access to the entire amount in the account.[10] This policy could leave the spouse in the community with few resources, after money in the account was spent down on the cost of nursing home care to a level that qualified the institutionalized spouse for Medicaid coverage. However, NGA also found that, because the community spouse also had full access to the account, he or she could make withdrawals without penalty.

With regard to rules for the treatment of income following eligibility, Federal Medicaid regulations have allowed a nursing home resident to set aside some of his or her income to provide for the maintenance needs of a spouse (and other dependents, if any) remaining in the community with little or no income.[11] Federal regulations have limited this amount to the highest cash assistance or medically needy income standard in use for Medicaid purposes in the State. Income that is not protected for this and other purposes must be paid toward the cost of nursing home care.

To illustrate the impact of this policy on spouses remaining in the community, table C–6 shows the amounts that States allowed to be set aside in 1987 for the support of a spouse. For spouses in the community with income that was below these amounts, institutionalized individuals were permitted to allocate an amount sufficient to raise the outside spouse's total income to the specified level.

Table C–6 indicates that amounts protected under this policy for the outside spouse ranged from $150 per month (or 32.7 percent of the 1987 Federal poverty level for an individual) in Tennessee to $550 (120 percent of poverty) in California. Thirteen States used the SSI standard (74.2 percent of poverty) to protect amounts for the maintenance needs of the outside spouse, and 20 States protected more than the SSI level. Seventeen States protected amounts that were less than the basic SSI payment level. Where the protected level was less than SSI, an aged or disabled outside spouse who met the SSI resource eligibility criteria could apply for SSI benefits and then receive at least the SSI benefit level, currently $354 per month. In addition to these basic amounts, eight States allowed additional amounts to be protected if ordered by a court to do so.

Public Law 100–360 will have a major impact on the amounts of income and resources that States will be required to protect for spouses remaining in the community.[12] Under new law, effective September 30, 1989, States will be required to set aside a sufficient amount of the institutionalized spouse's income to raise the community spouse's income to at least the following levels: effective September 30, 1989, 122 percent of the Federal poverty level for a couple (currently $786 per month); effective July 1, 1991, 133 percent of the Federal poverty level for a couple; and effective July 1, 1992, 150 percent of the Federal poverty level for a couple. An additional amount must be set aside when mortgage expenses or rent, plus utility costs, exceed 30 percent of the previously mentioned amounts. The monthly protected income level for a community spouse could not exceed $1,500, except where a higher level is determined necessary by fair hearing or court order. These amounts differ markedly from the maintenance needs amounts shown in table C-6.

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[10] Medicaid Eligibility for the Elderly in Need of Long Term Care, p. 43.

[11] Medicaid Eligibility for the Elderly in Need of Long Term Care, p. 47. This discussion closely follows findings of this report.

[12] These provisions are described in greater detail in chapter II.

With regard to resources, the new law will require that a one-time determination of countable resources be made at the time of application for benefits. This determination is to be based on all countable resources held by either the institutionalized spouse, the community spouse, or both, on the day the institutionalized spouse begins the continuous period of institutionalization. The couple's home, household goods, and personal effects are to be excluded from the calculation.

Once total joint resources are determined, one-half of the value of all these resources, known as the spousal share, would be attributed to each spouse. If the spousal share of the community spouse is less than $12,000, the institutional spouse would be allowed to transfer a sufficient amount to enable the community spouse to hold $12,000 in his or her own name. The State could raise the $12,000 minimum resource allowance for the community spouse to any level up to $60,000. The community spouse's share cannot exceed $60,000, except where a higher amount is provided under a fair hearing or court order. Any amounts in excess of $60,000 would be attributed to the institutionalized spouse and applied to the cost of care. Beginning in 1990, the $12,000 and $60,000 amounts will be increased by the percentage increase in the consumer price index. As in the case of protected monthly maintenance needs amounts, protected resources for the community spouse under new law will differ significantly from amounts that can be protected under current law. Under current law, if a State uses SSI policy to determine resources that may be protected for the community spouse, this amount would be $1,900.

Table C-6.—MONTHLY AMOUNTS NURSING HOME RESIDENTS ON MEDICAID ARE ALLOWED TO PROTECT FOR THE MAINTENANCE NEEDS OF AN OUTSIDE SPOUSE (AS OF THE SECOND QUARTER OF 1987), AND PERCENT OF 1987 FEDERAL POVERTY LEVEL

State	Dollar amount	Percent of 1987 Federal poverty level
Alabama	$340.00	74.2
Alaska	632.00	110.6
Arkansas	187.80	41.0
California [1] [3]	550.00	120.0
Colorado	229.00	50.0
Connecticut [2] [3]	458.33	100.0
Delaware	340.00	74.2
District of Columbia	362.00	79.0

Table C–6.—MONTHLY AMOUNTS NURSING HOME RESIDENTS ON MEDICAID ARE ALLOWED TO PROTECT FOR THE MAINTENANCE NEEDS OF AN OUTSIDE SPOUSE (AS OF THE SECOND QUARTER OF 1987), AND PERCENT OF 1987 FEDERAL POVERTY LEVEL—Continued

State	Dollar amount	Percent of 1987 Federal poverty level
Florida	340.00	74.2
Georgia	340.00	74.2
Hawaii	300.00	57.1
Idaho	413.00	90.1
Illinois [3]	Varies	......
Indiana	340.00	74.2
Iowa	340.00	74.2
Kansas	341.00	74.4
Kentucky	192.00	41.9
Louisiana	186.80	40.7
Maine	340.00	74.2
Maryland [3]	334.00	72.9
Massachusetts	455.00	99.3
Michigan [2] [3]	370.00	80.7
Minnesota [3]	402.00	87.7
Mississippi	340.00	74.2
Missouri	340.00	74.2
Montana	340.00	74.2
Nebraska	375.00	81.8
Nevada	173.00	37.7
New Hampshire	354.00	77.2
New Jersey	371.25	81.0
New Mexico	340.00	74.2
New York [3]	417.00	91.0
North Carolina	233.00	50.8
North Dakota	345.00	75.3
Ohio	258.00	56.3
Oklahoma	–0–	–0–
Oregon	341.70	74.6
Pennsylvania	372.40	81.3
Rhode Island	491.67	107.3
South Carolina	340.00	74.2
South Dakota	257.00	56.1
Tennessee	150.00	32.7
Texas	340.00	74.2
Utah	289.00	63.1
Vermont [2]	412.00	89.9
Virginia [2]	325.00	70.9
Washington [1]	368.00	80.3
West Virginia [3]	200.00	43.6
Wisconsin	442.72	96.6
Wyoming	195.00	42.5

[1] Uses community property laws to allocate income among spouses.

[2] Varies by geographic area; highest level shown.

[3] Will allow additional amounts to be protected if ordered by a court.

Source: U.S. Library of Congress. Congressional Research Service. Medicaid Eligibility for the Elderly in Need of Long-Term Care. CRS Report for Congress No. 87–986 EPW, by Edward Neuschler. September 1987. Center for Policy Research, National Governors' Association. Prepared under contract No. 86–46. p. 48–49.

C. THE DYNAMICS OF SPENDING DOWN TO BECOME ELIGIBLE FOR MEDICAID'S NURSING HOME BENEFIT

With nursing home care costing in the range of $22,000 a year, many elderly persons in nursing homes can quickly meet the resource and income requirements for Medicaid coverage of their care by spending down. Only very limited information is available about the spend-down process for Medicaid's nursing home benefit. No national data base exists that captures the utilization of nursing home care over time and the point at which Medicaid becomes the primary source of payment for that care. As a result, definitive answers are not available for questions about who is spending down, how long it takes for them to spend-down, and whether spend-down occurs after several short stays or long stays.

A 1983 General Accounting Office (GAO) report, *Medicaid and Nursing Home Care,* reviewed case studies and did other analysis that showed that one-quarter to two-thirds of Medicaid patients in nursing homes in certain areas initially entered as private paying patients and subsequently converted to Medicaid.[13] GAO also found that higher proportions of residents with longer nursing home stays were supported by Medicaid than those with shorter stays.

The 1985 National Nursing Home Survey provides limited information about persons shifting to Medicaid payment for their nursing home care. At the time of the survey, 605,800 residents (41 percent) reported that Medicaid was their primary source of payment at admission, and 885,700 residents (59 percent) reported that other non-Medicaid sources (i.e., own income or family support, Medicare, or other government programs) were the primary source of payment at admission.[14] For those not using Medicaid as the primary source of payment for their care at admission, 20.5 percent reported shifting to Medicaid at some point before the last month before the Nursing Home Survey interview. Data about the precise point when Medicaid became the primary source of payment—and the length of the spend-down process—was not collected by the survey. As figure C–4 shows, the percentage of persons shifting to Medicaid increased as duration of stay in the nursing home increased.

Another analysis published by the House of Representatives Select Committee on Aging provides estimates of the length of time of spend-down and the risk of impoverishment for elderly persons needing long-term care services. This study uses a microsimulation model of income and assets developed by the Urban Institute, together with data from the Medicare and Medicaid programs on the cost of long-term care services, to estimate the length of time elderly persons using long-term care services would find their income and assets spent down to the Federal poverty level. The study estimates that 70 percent of elderly persons living alone find their income spent down to the Federal poverty level after 13 weeks in a nursing home, and over 90 percent are impoverished within 1 year

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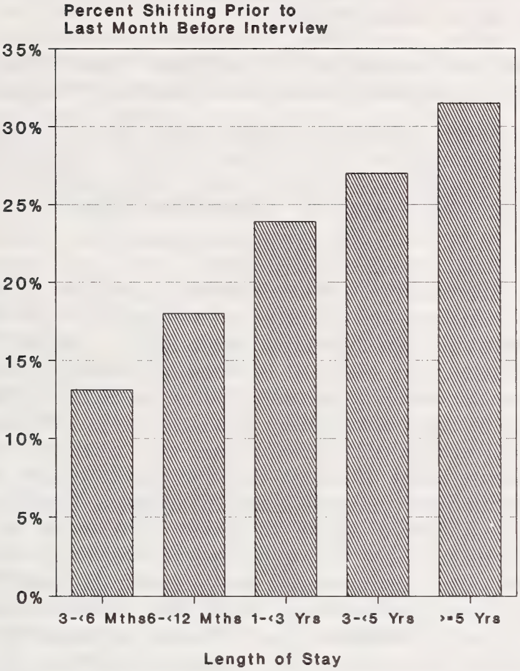
[13] U.S. General Accounting Office. Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly. GAO/IPE–84–1, Oct. 21, 1983. p. 25–26.

[14] U.S. Department of Health and Human Services. National Center for Health Statistics. Unpublished data from the 1985 National Nursing Home Survey.

Figure C-4
Percent of Current Residents Shifting to Medicaid As Primary Payer, By Length of Stay, 1985



Note: Value for residents with length of stay less than three months is too small to be reliable.

Source: Prepared by Congressional Research Service from unpublished data obtained from 1985 National Nursing Home Survey, National Center for Health Statistics, Department of Health and Human Services.

of admission.[15] When both income and financial assets were considered, nearly one-half of the elderly living alone are impoverished after 13 weeks in a nursing home and approximately two-thirds are impoverished within 1 year. For couples, 34 percent are impoverished after one spouse has spent 13 weeks in a nursing home and almost 80 percent are impoverished within 1 year when income alone is considered. When both income and assets are taken into account, almost one-half of couples are impoverished after 1 year in a nursing home.

D. MEDICAID ELIGIBILITY POLICIES AS THEY AFFECT PERSONS QUALIFYING FOR HOME AND COMMUNITY-BASED CARE

Over the years, observers have noted that Medicaid's eligibility policies and benefit structure have created financial incentives to use nursing home care rather than home and community-based care services. Until recently, Medicaid support for chronically impaired elderly persons living in the community had been quite limited. Many of the nonskilled personal care and supportive services needed by chronically impaired elderly persons in order to remain in the community were simply not covered under Medicaid. These services, however, are typically provided in nursing homes and are routinely covered as part of Medicaid's nursing home benefit. In addition, certain elderly persons, who were ineligible for Medicaid while living in the community because their incomes exceeded the State's limit, could become eligible for nursing home care at a higher income level if they resided in a State using a special income standard for persons needing nursing home care.

Congress addressed some of these problems in 1981 when it amended Medicaid law to authorize States to cover a broad range of home and community-based services for persons who would otherwise be eligible for nursing home care or other institutional care under the State's Medicaid plan. These services are often referred to as "2176 waiver services" after the section in the Omnibus Budget Reconciliation Act of 1981 that authorized them. See chapter VI for additional information about the 2176 waiver program.

Before the enactment of the 2176 waiver program, Medicaid services available to frail elderly persons living in the community were generally restricted to medical and medical-related services. The waiver authority acknowledges that a wide variety of other nonmedical services may be needed in order to prevent or postpone institutionalization. For this reason, certain services traditionally considered to be social services (other than room and board) are covered by the waiver authority. These include case management (commonly understood to be a system under which responsibility for locating, coordinating, and monitoring a group of services rests with a designated person or organization), homemaker/home health aide services, personal care services, adult day health, respite care, and other services that can contribute to the health and well-being of individuals and their ability to reside in a community-based setting. States have used this "other" category to provide home modifications and transportation services, among others. An NGA survey, in July 1987, found 37 States with operational waiver programs that serve elderly persons in at least some part of the State. About 59,000 elderly persons were being served in these programs.[16]

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[15] U.S. Congress. House. Select Committee on Aging. Long Term Care and Personal Impoverishment: Seven in Ten Elderly Living Alone Are at Risk. Pub. no. 100-631. Washington, Oct. 1987.

Under a 2176 waiver program, States may cover home and community-based services in only a portion of the State, rather than in all geographic jurisdictions as would be required absent a waiver. In addition, they may limit coverage of selected services to certain State-defined individuals eligible for assistance, rather than offering these services to all persons in particular eligibility groups. States may also determine eligibility for 2176 waiver services using the same more liberal income criteria used for determining eligibility for nursing home care, rather than the lower income limits usually applied to people living in their homes. Most States with 2176 waiver programs use these more liberal income standards.[17]

1. SINGLE INDIVIDUALS

However, 2176 waiver program beneficiaries who become eligible under these more liberal income criteria must pay part of the cost of care they receive.[18] The amount that they must pay for their care is determined after a deduction is made for their maintenance needs in the community. The amounts that single individuals eligible for 2176 waiver services were permitted to retain in 1987 to cover their maintenance needs at home are shown in table C–7. In the 37 States with programs serving the elderly, the amounts ranged from $233 to $1,020 per month, or from 50.8 percent to 222.5 percent of the 1987 Federal poverty level for an individual. Fourteen States provided the standard SSI amount of $340 per month (74.2 percent of poverty), 4 allowed less than that amount, and 19 permitted higher amounts. All income in excess of these maintenance needs amounts must be applied toward the cost of their home and community-based care services or other medical care. These maintenance needs amounts are, in addition, generally the same as amounts protected for the outside spouse of a nursing home resident. For 12 States, however, the maintenance needs allowance was higher for the beneficiary of 2176 waiver services than it was for the outside spouse of a nursing home resident.

Many nonmarried elderly persons living in the community may have fixed expenses which exceed the maintenance needs allowance permitted in the State. In addition, since resources must also be spent down to levels required for Medicaid eligibility, amounts that remain for the beneficiary receiving home and community-based care (generally less than $1,900 for single individuals) may be insufficient to cover the costs of repairs or replacements in the home and other exigencies. For the nursing home resident who is not expected to return to the community, Medicaid's resource test does not impose a comparable burden, since the individual is not likely to incur in the nursing home expenses that would require significant reserves.

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[16] Medicaid Eligibility for the Elderly in Need of Long Term Care, p. 34.

[17] Ibid.

[18] Ibid. This discussion closely follows findings of this report.

Table C–7.—AMOUNT OF INCOME AGED INDIVIDUALS RECEIVING MEDICAID FINANCED HOME- AND COMMUNITY-BASED SERVICES ARE PERMITTED TO RETAIN FOR MAINTENANCE NEEDS (AS OF THE SECOND QUARTER OF 1987) AND PERCENT OF FEDERAL POVERTY LEVEL

State	Program standard used	Dollar amount	Percent of 1987 Federal poverty level
Alabama	SSI	$340.00	74.2
California	MN	550.00	120.0
Colorado	SSP	398.00	86.8
Connecticut	2 x POV	916.66	200.0
Delaware	SSP	480.00	104.7
Florida	SSI	340.00	74.2
Georgia	SSI	340.00	74.2
Hawaii	MN	300.00	57.1
Idaho	SSP	413.00	90.1
Illinois	MN + $25	292.00	63.7
Indiana	SSI	340.00	74.2
Kansas	MN	341.00	74.4
Kentucky	SSI	340.00	74.2
Louisiana	SSI	340.00	74.2
Maine	SSI	340.00	74.2
Massachusetts	MN	455.00	99.3
Minnesota	MN	402.00	87.7
Mississippi	SSI	340.00	74.2
Missouri	SSI	340.00	74.2
Montana	SSI	340.00	74.2
Nevada	2 x POV	680.00	148.4
New Hampshire	SSP	354.00	77.2
New Jersey	SSP + $150	521.25	113.7
New Mexico	SSI	340.00	74.2
New York	MN	417.00	91.0
North Carolina	MN	233.00	50.8
North Dakota	MN	345.00	75.3
Ohio	MR	288.00	62.8
Oregon	SSP	341.70	74.6
Rhode Island	MN	491.67	107.3
South Carolina	SSI	340.00	74.2
Tennessee	SSI	340.00	74.2
Vermont	MN–2	617.00	134.6
Virginia	SSI	340.00	74.2
Washington	MN	368.00	80.3
West Virginia	3 x SSI	1,020.00	222.5
Wisconsin	SSP	442.72	96.6

Legend: SSI: Supplemental Security Income
SSP: State Supplementary Payment
MN: Medically Needy Level
MN–2: Medically Needy Leval for 2 persons.
MR: More Restrictive Standard of a 209–B State.
POV: Official Poverty Level for an individual.

Source: U.S. Library of Congress. Congressional Research Service. Medicaid Eligibility for the Elderly in Need of Long-Term Care. CRS Report for Congress No. 87–986 EPW, by Edward Neuschler, Sept. 1987. Center for Policy Research, National Governors' Association. Prepared under contract No. 86–26. pp. 36–37.

2. COUPLES

When the person needing home and community-based care under a 2176 waiver has a spouse living at home, income of the nonapplicant spouse is generally not deemed to be available to the person qualifying for care, and any resources that are held solely in the nonapplicant spouse's name are protected for the nonapplicant.[19] As table C–8 shows, 22 of the 37 States with 2176 waiver programs serving the elderly considered neither the separate income nor the separate resources of the nonapplicant spouse to be available to the applicant. One State (West Virginia) considered income and resources to be available only for the first 6 months during which 2176 waiver services are received (paralleling the State's policy for institutionalized cases). Thereafter, the spouse's income or resources are not considered to be available to the applicant. Two States (Missouri and North Dakota) did not consider the spouse's income to be available but did consider the spouse's resources to be available indefinitely, and one State (Oregon) counted the spouse's income but not resources. Nine States followed the SSI rules for spouses living in the same household, that is, income and resources were considered mutually available while the couple lives together. Two additional States (Alabama and Mississippi) provided 2176 waiver services only to SSI cash recipients. These various State policies on the availability of the income and resources of the nonapplicant spouse may affect a person's decision to elect waiver services as opposed to nursing home care.

Table C–8.—ARE THE INCOME AND RESOURCES OF A NONAPPLICANT OR INELIGIBLE SPOUSE TREATED AS BEING AVAILABLE TO AN APPLICANT FOR MEDICAID-FINANCED HOME- AND COMMUNITY-BASED SERVICES? (AS OF THE SECOND QUARTER OF 1987)

State	Income available?	Resources available?	Use SSI rules for couples?
Alabama	YES	YES	YES
California	YES	YES	YES
Colorado	YES	YES	YES
Connecticut	NO	NO	NO
Delaware	NO	NO	NO
Florida	NO	NO	NO
Georgia	NO	NO	NO
Hawaii	YES	YES	YES
Idaho	NO	NO	NO
Illinois	YES	YES	YES
Indiana	YES	YES	YES
Kansas	NO	NO	NO
Kentucky	YES	YES	YES
Louisiana	NO	NO	NO
Maine	NO	NO	NO
Massachusetts	NO	NO	NO
Minnesota	YES	YES	YES
Mississippi	YES	YES	YES
Missouri	NO	YES	NO
Montana	NO	NO	NO
Nevada	NO	NO	NO
New Hampshire	NO	NO	NO
New Jersey	NO	NO	NO
New Mexico	NO	NO	NO
New York [1]	YES	YES	YES
North Carolina	NO	NO	NO
North Dakota	NO	YES	NO

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[19] Medicaid Eligibility for the Elderly in Need of Long Term Care, p. 53. This discussion closely follows findings of this report.

Table C–8.—ARE THE INCOME AND RESOURCES OF A NONAPPLICANT OR INELIGIBLE SPOUSE TREATED AS BEING AVAILABLE TO AN APPLICANT FOR MEDICAID-FINANCED HOME- AND COMMUNITY-BASED SERVICES? (AS OF THE SECOND QUARTER OF 1987)—Continued

State	Income available?	Resources available?	Use SSI rules for couples?
Ohio	YES	YES	YES
Oregon	YES	NO	NO
Rhode Island	NO	NO	NO
South Carolina	NO	NO	NO
Tennessee	NO	NO	NO
Vermont	NO	NO	NO
Virginia	NO	NO	NO
Washington	NO	NO	NO
West Virginia	6 MOs.	6 MOs.	6 MOs.
Wisconsin	NO	NO	NO

[1] Spouse's income and resources are not considered available to applicant for some cases in five participating counties.

Source: U.S. Library of Congress. Congressional Research Service. Medicaid Eligibility for the Elderly in Need of Long-Term Care. CRS Report for Congress No. 87–986 EPW, by Edward Neuschler, Sept. 1987. Prepared under contract No. 86–26. pp. 52–53.

Table C–9 shows the amount of income protected in 1987 for maintenance needs when the person receiving 2176 waiver services lives with a spouse. States use two approaches in determining amounts of income protected for the maintenance needs of a household when one person of a couple receives 2176 services. In 27 of the 37 States with waiver programs for the elderly, the amount protected for the couple is the sum of the amount protected for the maintenance needs of the person receiving services plus an amount the beneficiary is permitted to protect for the needs of his/her spouse. (The allocation for the spouse is reduced if the spouse has any income of his/her own.) In the remaining 10 States, the amount protected is based on a "couple" standard. Their incomes are combined and the amount they are permitted to retain for maintenance needs is based on a standard developed for a household of two people. It should be noted that the new "spousal impoverishment" rules for determining amounts of resources and income that may be protected for the community spouse of a nursing home resident will also apply to couples where one spouse is receiving 2176 waiver services.

In 28 States, the amounts protected were more generous than the SSI standard for a couple (in 1987, $510). Only 5 States protected less than the SSI couple standard, and 4 States used exactly that standard (in 1987, $510 per month). The protected amount was greater than the poverty level in 23 States. These protected levels may allow couples, with one spouse eligible for 2176 waiver services, to manage the cost of care and other living expenses more easily than individuals without spouses.

Table C–9.—AMOUNT OF INCOME AGED COUPLES ARE PERMITTED TO RETAIN FOR MAINTENANCE NEEDS WHEN ONE SPOUSE IS RECEIVING MEDICAID-FINANCED HOME- AND COMMUNITY-BASED SERVICES AND THE OTHER IS INELIGIBLE OR NOT APPLYING FOR MEDICAID (AS OF THE SECOND QUARTER OF 1987)

State	Total amount allowed for the couple	Percent of 1987 Federal poverty level for couple
Alabama	$510.00	82.7
California	850.00	137.8
Colorado	627.00	101.7
Connecticut	1,375.00	223.0
Delaware	820.00	133.0
Florida	680.00	110.3
Georgia	680.00	110.3
Hawaii	400.00	56.5
Idaho	826.00	133.9
Illinois	358.00	58.1
Indiana	680.00	110.3
Kansas	682.00	110.6
Kentucky	532.00	86.3
Louisiana	526.80	85.4
Maine	680.00	110.3
Massachusetts	910.00	147.6
Minnesota	502.00	81.4
Mississippi	510.00	82.7
Missouri	680.00	110.3
Montana	510.00	82.7
Nevada	935.00	151.6
New Hampshire	511.00	82.9
New Jersey	892.50	144.7
New Mexico	510.00	82.7
New York	609.00	98.8
North Carolina	233.00	37.8
North Dakota	690.00	111.9
Ohio	546.00	88.5
Oregon	683.40	110.8
Rhode Island	983.34	159.5
South Carolina	680.00	110.3
Tennessee	490.00	79.5
Vermont [1]	1,029.00	166.9
Virginia	665.00	107.8
Washington	736.00	119.4
West Virginia	1,020.00	165.4
Wisconsin	885.44	143.6

[1] Varies by geographic area; highest level shown.

[2] Will allow the highest amount if ordered by a court.

Source: U.S. Library of Congress. Congressional Research Service. Medicaid Eligibility for the Elderly in Need of Long-term Care. CRS Report for Congress No. 87–986 EPW, by Edward Neuschler, Sept. 1987. Center for Policy Research, National Governors' Association. Prepared under Contract No. 86–26. pp. 55–57.

E. Quality of Nursing Home Care Services

Congress has been concerned about the quality of long-term care services, especially nursing home care, for many years. Hearings on quality issues in nursing homes have been held many times over the past 25 years, bills have been introduced, and legislation has been enacted.

Most recently, attention has focused on the findings of an Institute of Medicine (IOM) report, *Improving the Quality of Care in Nursing Homes,* published early in 1986.[20] The Health Care Financing Administration (HCFA) had requested IOM in 1983 to undertake a comprehensive study of nursing home regulations that apply to facilities participating in Medicare and Medicaid and to make recommendations on any changes that should be made to assure quality of care provided by these institutions. This study was requested following controversy generated by regulations proposed by HCFA in 1982 to revise regulatory requirements for nursing homes. Among other things, the proposed changes would have eased the annual inspection and certification requirements for facilities with a good record of compliance. They also would have allowed States to accept accreditation of nursing homes by the Joint Commission on Accreditation of Hospitals (JCAH), in lieu of State inspections, as a basis for certifying nursing homes as meeting Federal requirements for participation in Medicare and Medicaid. Following the publication of these proposed regulations, Congress twice enacted legislation prohibiting the Secretary of Health and Human Services (HHS) from implementing them.

The IOM found that the quality of care and quality of life in many nursing homes are not satisfactory and that more effective government regulation, including a stronger Federal role, could substantially improve quality in nursing homes. To accomplish this, the IOM report recommended (1) specific changes in the standards of care that nursing homes must meet in order to participate in Medicare and Medicaid, with an emphasis on standards demonstrating the actual performance of a facility in providing care; (2) measures to strengthen the process for determining the extent to which nursing homes are complying with standards for providing quality care; and (3) improvements in enforcing compliance with Federal standards.

The IOM's recommendations served as the basis for nursing home reform legislation included in OBRA87. The enacted legislation comprehensively reforms provisions in Medicaid law applying to nursing homes participating in Medicaid. With regard specifically to the Medicaid provisions, the new law eliminates, effective October 1, 1990, the current law distinction between SNFs and ICFs participating in Medicaid and creates instead a "nursing facility" benefit under the program. For these facilities, the law establishes a single set of requirements that must be met in order to participate in Medicaid. OBRA87 also establishes new requirements for the survey and certification process for nursing facilities participating in Medicaid. In addition, this law expands the remedies available to States and the Secretary of HHS for sanctioning noncompliant nursing facilities. These provisions are described in greater detail in chapter VII.

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[20] Institute of Medicine. Improving the Quality of Care in Nursing Homes. National academy press. Washington, D.C., 1986.

APPENDIX D. MEDICAID SERVICES FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS [1]

INTRODUCTION

Persons with mental retardation have significant subaverage intellectual functioning accompanied by deficiencies in skills such as self-care and independent living. Persons with conditions related to mental retardation are those with severe chronic disabilities that result in impaired intellectual functioning or deficiencies in skills similar to the deficiencies experienced by persons with mental retardation. Persons with mental retardation or related conditions may be multiply handicapped with mental and physical impairments; their impairments may range from moderately to profoundly incapacitating.

Most persons with mental retardation or related conditions are able to live in community-based homes with their families or other persons who can offer assistance. These persons can generally participate in daytime activities, including programs that offer training ranging from self-help habitation programs to prevocational or supported employment programs. However, some persons with mental retardation or related conditions require more intensive services, and many of these most severely impaired persons are served in residential facilities that offer comprehensive, continual care.

The major source of Federal financing for health care services for persons with mental retardation or related conditions is the Medicaid program.[2] Medicaid can provide coverage for the health and health-related services included under a State's plan to all persons with disabilities who meet eligibility requirements.

Most Medicaid services designed specifically for this population are delivered in large Medicaid-certified residential institutions known as intermediate care facilities for the mentally retarded (ICFs/MR). ICFs/MR provide 24-hour care and range in size from State or private facilities of 15 beds or fewer to very large State-operated institutions of over 1,000 beds. Some Medicaid funding is also used for community-based services for this population under the Medicaid "2176" waiver program, but participation of this population in the waiver program is relatively small (See chapter V.)

Because Medicaid services are primarily limited to health and health-related care, most community-based residential and day training programs for persons with mental retardation or related conditions are supported with separate State funding. These State funds are used for community residential services, case management, respite care, daytime training programs, and other services required to enable these disabled persons to live and function in community settings.

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[1] This appendix was prepared by Mary F. Smith.

[2] The Medicaid program is authorized under title XIX of the Social Security Act. Medicaid is financed by both Federal and State funds. Federal contributions to each State are based on State spending on eligible services and a matching formula.

Many persons have advocated that additional funding is needed for community services to meet the needs of persons cared for by families and to assist those being transferred out of large institutions. There are rising expectations on the part of parents that most of these disabled persons are capable of living in the community with some degree of independent functioning. Some advocacy groups have sought to have more Medicaid funding made available for community services and to limit Medicaid funds for the larger institutions. However, these efforts have been resisted by other advocacy groups who oppose restrictions on institutional funding and by those with concerns regarding the potential costs of using Medicaid funding for community services for this population.

This appendix will discuss the service needs of persons with mental retardation or related conditions, issues associated with service delivery to this population, the types of Medicaid services provided, and costs and trends related to these services.

I. BACKGROUND

A. Target Population

Three percent of the population of the United States may be limited by mental retardation at some time in their lives.[3] The American Association on Mental Retardation defines mental retardation as follows: [4]

> Mental retardation refers to significant subaverage general intellectual functioning resulting in or associated with concurrent impairments in adaptive behavior and manifested during the developmental period.

Significant subaverage intellectual functioning is defined as an I.Q. of 70 or less, and impairments in adaptive behavior are inabilities to perform personal and interpersonal functions at levels appropriate to the age of the individual.[5] The developmental period is childhood and adolescence.[6]

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[3] Data on the prevalence of mental retardation and degrees of severity are taken from Scheerenberger, R.C., A History of Mental Retardation: A Quarter Century of Promise. Brookes Publishing Company, Baltimore, MD, p. 13 to 20.

[4] Grossman, H., Classification in Mental Retardation. Washington, D.C.. American Association on Mental Deficiency. (Currently called the American Association on Mental Retardation.) 1983, reported in Scheerenberger.

[5] Persons with mental retardation are classified according to degree of intellectual impairment as measured by I.Q.: mild mental retardation, I.Q. of 50–55 to 70; moderate mental retardation, I.Q. of 35–40 to 50–55; severe mental retardation, I.Q. of 20–25 to 35–40; profound mental retardation, I.Q. below 20 or 25. Source: Grossman, H., Classification in Mental Retardation. Washington, D.C., American Association on Mental Deficiency. (Currently called the American Association on Mental Retardation.) 1983. p.13.

[6] Whereas mental retardation is diagnosed as a failure in intellectual development that results in limited competence, mental illnesses are psychiatric disorders affecting emotions and include neuroses, psychoses, and organic dysfunctions. Both mental retardation and mental illness can result in incompetent behavior if the impairments are severe. An individual can have a dual diagnosis of both mental retardation and mental illness, but one impairment is generally specified as the primary diagnosis.

Continued

Medicaid regulations define "persons with related conditions" as individuals who have a severe, chronic disability that is attributable to cerebral palsy or epilepsy or any other condition, other than mental illness, that results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation.[7] Persons with related conditions must require treatment or services similar to services required by persons with mental retardation. The regulation specifies that the disability must be manifest prior to age 22, be likely to continue indefinitely, and result in substantial functional limitations in three or more areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, or a capacity for independent living.

Persons with mental retardation or related conditions are limited in personal and interpersonal functions, also referred to as behavioral deficits, deficits in adaptive behavior, or functional limitations. These terms refer to the inability to perform activities such as feeding, toileting, bathing, or dressing oneself; speaking or understanding verbal communication; interacting cooperatively with others; learning in school; and living independently. These terms also include inabilities to engage in regular employment; to use public transportation; and to shop or manage money independently. A person is functionally impaired to the extent that he or she is unable to perform the usual activities appropriate for his or her age group.

Two-thirds of those with mental retardation are persons who are unable to achieve satisfactorily in the school system. However, this group is generally able to function within society's norms without assistance when not in school and after the years of schooling are over. The most disabled one-third of the mentally retarded population is unable to function within society's norms even when out of school. It is estimated that this one-third, i.e., 1 percent of the U.S. population or approximately 2.4 million persons, is impaired to the extent that they are in need of special supervision, treatment, or services.[8]

In contrast to the 2.4 million persons discussed above, the Health Care Financing Administration (HCFA) estimates that approximately one million persons are so severely disabled by mental retardation or related conditions that they could benefit from lifelong services, delivered primarily in community-based settings.[9]

The term developmental disability, as defined under the Developmental Disabilities Assistance and Bill of Rights Act, can include any severe, chronic mental or physical disability with onset prior to age 22. A person with mental retardation or mental illness could be developmentally disabled if the individual's impairment resulted in substantial functional limitations in major life activities as defined under the Developmental Disabilities Act. Functional limitations specified under such act include deficits in self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

[7] 51 *Federal Register* 19181, published May 28, 1986.

[8] Many of these persons are children under age 22 who live with their families and are provided special education and supportive services under the Education of the Handicapped Act. In school year 1985–1986, 686,077 children with mental retardation were served under this program. Source: Ninth Annual Report to the Congress on the Implementation of the Education of the Handicapped Act: Department of Education. 1987. Information on the severity of mental retardation of these children is not available.

[9] This estimate was made as part of a HCFA estimate of cost and beneficiary impact of the proposed Medicaid Home and Community Quality Services Act of 1987, Mar. 11, 1988. HCFA did not provide the assumptions used for this estimate.

HCFA estimates that these one million persons with mental retardation or related conditions are eligible for Medicaid. Most of these persons are eligible for Medicaid as a result of their eligibility for Supplemental Security Income (SSI) as disabled persons.[10] These persons are not only substantially mentally impaired (generally with an I.Q. of 50 or below), but are also functionally disabled and are unable to perform the usual daily activities appropriate for persons in their age group.

Persons with mental retardation or related conditions are eligible for Medicaid services if they meet the definition of disability and if they meet income and resource eligibility requirements. Income and resource eligibility is generally determined by eligibility for SSI. (See chapter II; Eligibility.)[11]

In determining eligibility for a child under age 21, the income and resources of the parents are considered available, or "deemed," to the child if the child is living in the same household as the parents. A child in an ICF/MR or other Medicaid institution is not considered to be living with the parents after 1 month of institutionalization. Subsequently, only the income actually contributed by the parents of the institutionalized child is considered. Medicaid law also authorizes services to certain disabled children living at home if the child would be eligible for Medicaid if institutionalized, and if other conditions are met.[12] (See chapter II; Optional coverage of noninstitutionalized disabled children.)

B. SERVICES NEEDED

Many persons with severe mental retardation are multiply handicapped and may also have cerebral palsy, epilepsy, or other impairments which affect the central nervous system. Some individuals with the most severe impairments, including many who are profoundly retarded, are medically fragile and require frequent medical and nursing care to sustain life.

The need for supportive services for persons with mental retardation or related conditions is due to their inability to function independently in activities of daily life that might include self-care, sensory and motor skills, use of language, and management of finances. These are persons who are likely to have limited language development, limited housekeeping and vocational abilities, and may exhibit antisocial behavior.[13] Persons with mental retardation who have substantial behavioral deficits require supervised living arrangements and daytime services. These persons can receive services in institutional or community-based settings, depending on service availability and family preference.

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[10] The supplemental security income program is authorized under title XVI of the Social Security Act.

[11] Medicaid-eligible persons with mental retardation or related conditions have covered medical services paid for like any other eligible person. Since there is no separate eligibility category for persons with mental retardation, total program expenditures by the program for health services for persons with mental retardation cannot be isolated from expenditures for other Medicaid clients. However, data for ICF/MR services and limited community care are available.

[12] Public Law 100-360, the Medicare Catastrophic Coverage Act of 1988, specified that States cannot disallow Medicaid payments for educationally related services based on the fact that such services are included in an individualized education plan required under the Education of the Handicapped Act. The conference report accompanying Public Law 100-360 clarified that Federal Medicaid matching funds are available for health services covered under a State's Medicaid plan even though such services are included in the individualized education plan required for handicapped children under the Education of the Handicapped Act. Whereas the State education agencies are responsible for educational services, Medicaid agencies are responsible for the related services required to meet the needs of eligible handicapped children. Such services could include speech pathology and audiology, psychological services, physical and occupational therapy, and other related services needed to meet the unique needs of eligible handicapped children.

Daytime services include supervised activities such as habilitation services, generally defined as training in the skills of daily living, self-help, and socialization skills. Habilitation services can also include prevocational or vocational training, or supported employment. Prevocational training includes skills such as paying attention to a task and maintaining time schedules, which are necessary to prepare to learn job skills. Vocational training includes skills needed to perform a job. Supported employment services include special assistance to allow a severely disabled person to enter and maintain employment in work settings with nondisabled persons.

Daytime programming can also include day activity centers (which do not stress productive economic output), and sheltered workshops (in which subminimum wages are paid according to the productivity of disabled persons). Respite care is also provided to give the family caring for a disabled person time for rest, recreation, and other activities. Services covered under Medicaid are discussed below.

C. HISTORY

Historically, many persons with severe mental retardation or related conditions were placed in large custodial institutions which were generally located in rural, isolated settings. Normal community involvement of these institutionalized persons was not generally accepted practice. Prior to the 1950's, these institutions were virtually the only place that any services were available for persons with mental retardation. Many families were encouraged by their physicians to institutionalize severely handicapped newborns at birth. Conditions in these institutions were generally harsh, treatment programs were limited, and the institutions were crowded. Such facilities served as custodial settings where many people remained for years.[14]

In the 1950's, parents of retarded children began to organize and to encourage the development of community services so that their handicapped children could receive specialized developmental services while living at home. These parents also worked to bring about improvements in institutions. In 1962, a panel of experts appointed by President Kennedy recommended that institutional care be restricted to those retarded persons whose specific needs could best be met with this type of service. This panel also recommended that local communities, in cooperation with Federal and State agencies, undertake the development of community services for persons with mental retardation. Abuse and neglect of institutionalized retarded persons were reported in the press, and during the 1960's and 1970's efforts were made to improve conditions in institutions, expand alternatives to institutionalization, and move residents from institutional to community settings.

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[13] This listing is intended to include examples of the major types of impaired functioning that may be exhibited by persons with mental retardation, but it is not intended to imply that all persons with mental retardation exhibit all these behaviors. Also, many persons with mental retardation have improved their level of functioning due to modern training techniques and behavior modification designed to ameliorate or modify antisocial behavior.

[14] For further information on conditions in early institutions, see U.S. General Accounting Office. Summary of a Report. Returning the Mentally Disabled to the Community: Government Needs to do More; Report to the Congress by the Comptroller General of the United States. HRD-76-152A, Jan. 7, 1977. Washington, 1977.

Over the past 20 years, services have been developed in many communities to help families provide care for persons who might otherwise require institutionalization and to provide community living arrangements for persons coming out of institutions. Over this period there has been a steady decline in the number of persons with mental retardation served in public residential institutions, as shown on figure D–1. This decline resulted in a 51 percent reduction in the institutionalized population from 194,650 in fiscal year 1967 to 94,565 in fiscal year 1987. These numbers include only those persons served in large public residential facilities, and do not include persons served in private residential facilities or group homes in community-based settings.

Several pieces of landmark legislation have been enacted by Congress to provide services and protection for persons with mental retardation and related conditions. Among these was the 1972 authorization of Federal Medicaid funding for care provided in ICFs/MR. To participate in Medicaid and receive ICF/MR funds, an institution must meet Federal standards established under the Medicaid program to assure appropriate treatment, a safe environment, and qualified staff. The ICF/MR program has served, and continues to serve, as a major incentive for States to improve conditions in their institutions for the mentally retarded in order to qualify for Federal Medicaid payments.[15]

D. MEDICAID SERVICES

Prior to the 1970's, virtually all public services for persons with mental retardation or related conditions were supported with State funds and were delivered in large State residential institutions. Since the 1970's, Medicaid funds have become a major funding source for services for these persons. Between fiscal year 1977 and fiscal year 1986, Medicaid expenditures for persons with mental retardation or related conditions increased from $1.1 billion to $5.7 billion. Most of this funding was used for services in large State ICFs/MR. Growth in ICF/MR expenditures resulted from: (1) the Medicaid certification of beds in State residential institutions as those facilities were brought into compliance with the requirements of the ICF/MR program, and (2) increases in expenditures per person. Also, the use of ICF/MR funds in private residential facilities increased substantially over this period. On June 30, 1986,

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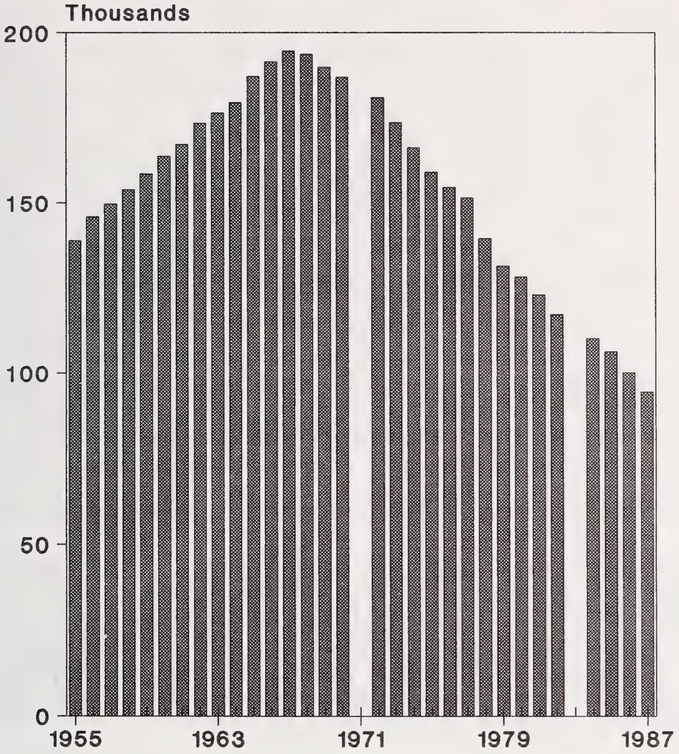
[15] Other legislation that influences services to persons with mental retardation or related conditions includes: (1) The Developmentally disabled Assistance and Bill of Rights Act, which requires statewide planning and coordination of services for this population, (2) the Education of the Handicapped Act, which requires that appropriate educational and supportive services be provided to all handicapped children, including persons with mental retardation or related conditions, and (3) the Civil Rights of Institutionalized Persons Act, which gives the U.S. Attorney General explicit authority to initiate and intervene in litigation involving the constitutional rights of institutionalized persons.

Figure D-1
Average Daily Population of Public Residential Facilities for the Mentally Retarded, 1955-1987



Source: K. Charlie Lakin, Center for Residential and Community Services, University of Minnesota. Data not available for 1971 and 1983.

143,815 persons with mental retardation or related conditions were served in public and private ICFs/MR of all sizes. (This number does not include residential facilities that were not ICF/MR-certified.) Total Federal and State ICF/MR service costs equalled $5.2 billion in fiscal year 1986.[16] (These data are presented in detail in section IV of this appendix.)

In addition to those served in ICFs/MR, on June 30, 1986, 23,053 persons with mental retardation or related conditions were receiving services under the home and community-based waiver program in 33 States at a cost of $261 million. (See chapter V; Community Care Under the 2176 waiver.) Waiver services are designed for persons who would require institutionalization in the absence of the waiver program. States must assure that the estimated average per capita expenditure for medical assistance in any fiscal year for those receiving waivered services will not exceed the average per capita expenditure that the State reasonably estimates would have been incurred in that year for that population if the waiver had not been granted. That is, the services offered under the waiver may not cost more than services that would have been required had the individuals received services in an ICF/MR. Also, under HCFA requirements, States must demonstrate that ICF/MR beds are actually available or would be available (through construction certification) for persons served under the waiver program. This requirement limits the growth of the waiver program because ICFs/MR are generally operated at or near capacity. Also, the program has been viewed as experimental and services available under the waiver (except case management) are not a permanent option under Medicaid .

Nineteen States have included day treatment programs for some persons with mental retardation or related conditions as part of the State Medicaid plan. These programs provide rehabilitative and developmental training services to persons living in family homes or in small community-based residences. On June 30, 1986, $194 million was used for this purpose. Data are not available on the number of persons served in these programs.

The only way persons with mental retardation or related conditions are able to receive Medicaid-funded supportive or training services is to be accepted by the State as a resident of an ICF/MR or a participant in a community-based waiver or day treatment program. This method of selection may help assure support for services for some of the most severely handicapped persons. However, there are other persons living in community settings who are eligible for Medicaid and are as disabled as, or more disabled than, some of the persons whose services are supported under the ICF/MR or waiver programs. The majority of these community-based persons do not have Medicaid-supported habilitation services available to them because they have not been accepted into a Medicaid-funded program. States can limit these services simply by controlling the number of ICF/MR beds (there are waiting lists in many areas) and by limiting the number of persons accepted into the waiver and day treatment programs.

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[16] Braddock, David; Richard Hemp; and Glenn Fujiura. Public Expenditures for Mental Retardation and Developmental Disabilities in the United States: State Profiles (2nd edition), Public Policy Analysis Program, University Affiliated Facility for Developmental Disabilities, Institute for the Study of Developmental Disabilities, University of Illinois at Chicago, Sept. 19, 1986. Federal ICF/MR expenditures were reported at Braddock at p. 65. State ICF/MR expenditures were calculated by the Congressional Research Service (CRS) as the sum of ICF/MR expenditures by the States and the District of Columbia, which were calculated from the Federal financial participation rates and Federal ICF/MR expenditures reported in Part 3 of Braddock.

E. STATE SERVICES (NON-MEDICAID)

Most of the persons with mental retardation or related conditions that are estimated to be eligible for Medicaid are not served in ICFs/MR or under the waiver. (Medicaid pays only for medical services for community-based persons not served in the waiver or day treatment programs.) Separate State programs are serving an undetermined number of these remaining persons at a total cost to the States of $2.8 billion. Most of the State-funded services consist of daytime services for disabled persons living with their families and residential services delivered in small group homes in the community (that are not ICFs/MR). The reason that many small State-funded group homes are not certified as ICFs/MR is that the level of care and the life safety requirements under the ICF/MR program would require increased expenditures. For group homes serving mildly and moderately retarded persons, these expenditures are often considered by States to be not necessary. However, as severely and profoundly retarded persons are increasingly served in group homes, ICF/MR certification of these homes may increase.

F. CAUSES OF MENTAL RETARDATION AND RELATED CONDITIONS

Mental retardation and related conditions are caused by a variety of factors, including genetic anomalies, birth trauma, head injury (including child abuse), diseases of the central nervous system, and adverse prenatal influences. Adverse prenatal influences relate to conditions of pregnant women that affect the fetus, including drug or alcohol abuse, AIDS, infections, and poor nutrition, many of which tend to be associated with lower socioeconomic status.

The total number of persons with mental retardation or related conditions is affected by advances in medical care and life-saving devices, which may be having a dual effect on the incidence of these disabilities. (Data are not available to show the numerical effects of these influences.) For example, prenatal care for pregnant women can reduce the incidence of low birth weight newborns, who are at risk for mental retardation. Intensive care for premature infants allows some newborns to survive who would have died in the past; however, some of these infants are left with severe disabilities that require life-long care and treatment. Also, amniocentesis allows parents to know the disability status of their unborn children, and this offers parents information that may affect their choice regarding termination of pregnancy. Some persons become mentally retarded due to accidents such as near drowning or automobile collisions. In these cases, lifesaving techniques and seat belts save lives and prevent some injuries; and some persons who would have died are left with severe brain injury.

II. SELECTED ISSUES REGARDING THE EXPANSION OF COMMUNITY-BASED SERVICES

There has been criticism of the current service delivery system, in which a minority of persons with mental retardation or related conditions receive virtually all of the Medicaid residential and community-based services funding for this population. These concerns center on the following issues: (1) there is increasing demand to authorize additional Medicaid-funded community-based services and there is concern about related costs to the Federal Government, (2) there are varied assumptions and preferences regarding the appropriateness of institutional care versus community-based care, and (3) there is concern regarding quality assurance mechanisms for this population that focus on Federal versus State responsibility.

A. Increased Demand for Community-Based Services for Persons With Mental Retardation or Related Conditions

Deinstitutionalization, completion of special education, and the inability of aging parents to maintain disabled offspring at home have contributed to increased demand for community-based residential and daytime services for persons with mental retardation or related conditions. Many parents and professionals in the disability field are advocating for care settings that promote community integration and maximum independence. This philosophy is set forth in the Developmental Disabilities Assistance and Bill of Rights Act which is intended to promote independence, productivity, and integration into the community. The movement of disabled persons to the community is facilitated by public and private efforts to develop group homes, daytime training and therapeutic programs, employment opportunities, and family support services. Experience has shown that many disabled persons who were previously institutionalized or otherwise unproductive are capable of a degree of independent activity if the necessary training, supervision, and other assistance is provided. For example, many persons who were previously determined to require institutional care are now living in small, supervised community-based residences, taking public transportation to sheltered or supported jobs, participating in community recreation activities, receiving social services where needed, and leading semi-independent lives. If a crisis should occur, the individual may require intensive care or retraining, or may require temporary institutionalization.

The mandate under the Education of the Handicapped Act that States provide special education to all handicapped children has generated rising expectations regarding the opportunities that will be available to these young disabled people when they leave the school systems. Families accustomed to having educational and other support services available to their handicapped children see that, with help, these persons are capable of some degree of independence and productivity. Therefore, as the young people leave school, their families are advocating increased availability of group homes, supported employment, and the array of intervention services required to maintain the progress experienced through adolescence. Because the major source of Federal funds for disabled adults is the Medicaid program, advocates for disabled persons are looking increasingly to the Medicaid program to help support the array of services needed to sustain disabled persons in community-based settings. However, there may be difficulties in designing income and resource eligibility criteria that would make community-based services more broadly available, yet would limit coverage to those most in need.

One proposed expansion of Medicaid services for community-based persons with mental retardation or related conditions has been opposed by the Reagan Administration.[17] Objections were raised regarding the use of the Medicaid program as the funding source for certain community-based services, since Medicaid was originally intended to provide medical and medically-related services for the poor. The issue of cost of services to a potentially large population was also raised. It might be argued that community-based habilitation services are really social services, and are not strictly medical, or even medically related, services. According to this argument, Medicaid may not be the appropriate funding source for these services. However, habilitation services are currently authorized under the Medicaid waiver program to include training in self-help, socialization, and adaptive skills necessary for community-based living. The statute specifically authorizes prevocational and supported employment services under the waiver program. Therefore, it might be argued that Medicaid-eligible persons who would be at risk of institutionalization were it not for family care or State-funded habilitation services should be entitled more broadly than under the waiver to Medicaid-funded habilitation services in community-based settings.

B. Appropriate Settings for Residential Services for Persons With Mental Retardation or Related Conditions

There are differing assumptions and preferences regarding the type of residential service settings considered most appropriate by persons closely involved with the service delivery system. The following discussion is based on congressional testimony,[18] conversations with leading professionals in the disability field, representatives of interested advocacy groups, and with a representative of a public employees' union. It should be noted that most interested parents of persons with mental retardation are involved in advocating for expanded community-based services, but parents tend to be divided regarding whether services in the larger institutions should be reduced or maintained.

1. COMMUNITY-BASED RESIDENTIAL SERVICES

Advocates for increased community-based residential services hold the view that optimal individual functioning is facilitated for most, if not all, disabled persons if they live in a setting that is integrated into the community. The settings considered most appropriate are family homes, foster family homes, and family-scale residences from which disabled persons may receive an array of services both in the home and in the community. According to this position, large facilities are dehumanizing and degrading and are sometimes the locations of flagrant abuse and neglect. Because these institutions tend to be isolated from community activities and nondisabled role models, disabled persons can become less able to function in community settings after entering an institution, according to this argument. Also, some families of institutionalized persons would prefer to have their disabled family member in a community setting near the rest of the family. These advocates state that persons with mental retardation or related conditions do not need 24-hour institutional care if appropriate services are available in the community. For example, a family caring for a disabled family member might not seek institutionalization if respite care and other community services were available.

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[17] Discussion of Medicaid Home and Community Quality Services Act of 1987 (S. 1673) prepared by HCFA, Oct. 6, 1987.

[18] U.S. Congress. Senate Committee on Finance. Subcommittee on Health. Hearing on Medicaid Home and Community Quality Services Act, Mar. 22, 1988; and Public Hearing to Examine Medicaid Financing of Services for Developmentally Disabled Persons, Sept. 19, 1986; and Senate Hearing 98–775, Community and Family Living Amendments of 1983, Feb. 27, 1984.

Abuses in some institutions have provided further motivation for advocates of community-based services to seek ways to increase funding for community residential and service options. Testimony, presented at congressional hearings held in 1985, showed that, despite the upgrading of conditions resulting from ICF/MR standards, abuse and neglect continue to be serious problems at some institutions.[19]

Although empirical research on institutional versus community care is not conclusive, most studies tend to support the contention that community-based services conducted in as normal a setting as possible are more effective than institutional services in promoting developmental growth and independence of persons with mental retardation or related conditions. A move from institutional to community settings tends to result in positive social adjustment and improved behavioral development for many disabled persons.[20] However, for developmental growth to take place, according to research findings, the community setting must include certain essential features: effective teaching techniques, friendship networks for disabled persons, and active involvement and positive attitudes of care providers. Some research has found that institutional settings in which these features are present can also be effective settings for developmental growth and that reducing the size of a facility does not necessarily change the daily pattern of care.[21] However, small residential settings are more likely than large institutions to allow interaction with neighbors and to facilitate access to community experiences that enhance social, vocational, and recreational skills.[22]

Although community services are available under the 2176 waiver programs to some persons with mental retardation or related conditions who are at risk of institutionalization, waiver services are not available to all persons who need community-based services.

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[19] U.S. Congress. Senate. Committee on Labor and Human Resources. Subcommittee on the Handicapped. Abuse of Institutionalized Handicapped Persons. Hearings, Apr. 1, 2, and 3, 1985.

[20] Conroy, James, et al. A Matched Comparison of the Developmental Growth of Institutionalized and Deinstitutionalized Mentally Retarded Clients. American Journal of Mental Deficiency, v. 86, no. 6, 1982. p. 581–587.

[21] Selzer, Marsha. Known Effects of Environmental Characteristics on Resident Performance, LINKS, Feb. 1981.

[22] Baroff, George S. On Size and the Quality of Residential Care: A Second Look. Mental Retardation, v. 18, no. 3, June 1980. p. 113–117.

States provide most of the support for community-based services, and persons who advocate for expanded community services favor using Medicaid funding for these purposes.

2. INSTITUTIONAL SERVICES

Persons advocating continued use of institutional services as an option maintain the view that community services are desirable for those disabled persons for whom they are appropriate, but institutional services are essential for many of the most severely disabled persons. Persons with this view state that, due to ICF/MR standards, persons being served in institutional settings are generally receiving appropriate services and training. Some such persons state that comprehensive services delivered in an institutional setting under centralized authority are preferable to community services which may be fragmented and may lack a central point of authority. It is argued that the specialized staff working in institutions are better able to meet the medical, therapeutic, and other needs of severely disabled persons than are practitioners in the community who may not be familiar with the most severe disabilities. It is also argued that medically fragile persons who require intensive medical and nursing care can be served more economically in institutional settings. Some older parents favor a centrally administered institutional setting because they are concerned about the safety and security of their offspring when the parents are no longer able to serve as advocates.

Over the past decade, the less severely disabled persons increasingly have been transferred out of institutions, and generally only the most severely impaired, who require the most intensive services, remain. It is argued that a high quality institutional setting should be available as an option to serve this population.

Advocates for institutional services do not necessarily argue against the availability of community care, unlike many advocates for community services, who oppose institutional care. Advocates for institutional services state that there should be an array of services available to meet individual needs, ranging from small family-scale residences to high quality institutions, to meet the diverse needs of persons with mental retardation or related conditions. It is argued that critical factors determining quality of care are quality of staff, staff-client ratios, active family involvement, and on-site health and therapeutic services, not the size or location of the residential facility. Advocates for institutional alternatives raise questions about the quality of care in some community settings, concerns borne out by recent research on the Medicaid waiver program which indicated burnout and high turnover among direct care staff.[23]

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[23] Burwell, Brian O., The Maryland Medicaid Waiver Program for Persons with Developmental Disabilities: Case Study. systeMetrics/McGraw-Hill, Lexington, MA, June 1988. p. 39–42. Study was done under subcontract for HCFA.

C. QUALITY ASSURANCE ISSUES

To participate in Medicaid and receive reimbursement, ICFs/MR must meet Federal standards specified in regulations. The intent of the standards is to help assure that effective services are delivered, that safety standards are maintained, and that other criteria related to quality assurance are met. On June 3, 1988, HCFA issued a new regulation for ICFs/MR participating in Medicaid. (42 C.F.R. Part 483, Subpart D.) The new regulation sets forth conditions of participation for ICFs/MR. These conditions are designed to help assure: (1) the provision of active treatment services, (2) the protection of clients' rights, (3) a safe and appropriate physical environment, and (4) a qualified service-delivery staff.

The major issue regarding quality assurance in ICFs/MR is the enforcement of the ICF/MR regulation. Whereas the old regulation focused on facility policies as set forth on paper, the new regulation is designed to enable the facility and the monitoring agencies to assess whether appropriate treatment and other interventions are being planned and delivered. Specific standards are stated under each condition of participation to help clarify exactly what is required and to help determine the degree of compliance.

Under the 2176 waiver program, States are required to provide assurances that necessary safeguards have been taken to provide adequate protection for waiver beneficiaries. The regulation also specifies that State licensure or certification requirements for services must be maintained for the waivered services. However, the Federal regulation does not attempt to define the standards for waiver services or to state how they are to be developed.[24]

There is concern expressed by some persons in the disability field that as community-based services are developed and expanded to serve increasing numbers of persons with mental retardation, there is a need for the Federal Government to play an active role in the quality assurance process. According to this position, specific Federal requirements and Federal monitoring procedures are needed for community-based services for this population. Such persons point out that there is potential for abuse of clients in dispersed community-based residential settings where there are fewer staff to supervise care and observe neglect. It may also be more difficult for persons who monitor quality to determine whether clients are receiving quality services in numerous small settings. Persons expressing this concern state that prior to the promulgation of the ICF/MR standards in 1974, abuse and neglect were more prevalent in institutions. Institutional problems have been and continue to be corrected, they contend, due to the Federal Government's active role in promulgating and overseeing enforcement of the ICF/MR standards.

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[24] Most funding for community-based services is provided solely by the States, and the quality of these services is regulated by the States without Federal involvement.

III. MEDICAID SERVICES AND STANDARDS OF CARE

A. INSTITUTIONAL SERVICES COVERED UNDER MEDICAID FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS

1. SERVICES IN ICFS/MR

Institutional services delivered in ICFs/MR include medical and nursing services, physical and occupational therapy, psychological services, recreational services, social services, speech and audiology services, and other health and rehabilitative treatment and services. Medicaid law specifies that ICF/MR services may include services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions if, among other things: (1) the primary purpose of the institution (or distinct part thereof) is to provide health or rehabilitative services for mentally retarded individuals and the institution meets such standards as may be prescribed by the Secretary; and (2) the mentally retarded individual is receiving active treatment. The regulation specifies that each client must receive a continuous active treatment program which includes aggressive, consistent training and treatment to advance independent functioning and prevent loss of function already acquired. The active treatment requirement is implemented by means of an individual program plan that specifies client needs and objectives, and each client must receive continuous active treatment necessary to support these objectives.

ICF/MR funds are used for residential services in facilities ranging in size from small public or private residences of 15 beds or fewer to very large State-operated institutions of over 1,000 beds. Both large and small facilities are operated by States and by the private sector. Medicaid law has been interpreted by the Secretary of Health and Human Services (DHHS) to authorize the Secretary to make payments to private as well as public institutions that are certified according to ICF/MR standards. On June 30, 1986, about 144 thousand persons with mental retardation or related conditions were served in public and private Medicaid-certified ICFs/MR of all sizes.[25] Most institutionalized persons with mental retardation or related conditions are served in large State institutions, and almost all large State institutions are certified as ICFs/MR.

As shown on figure D–1, the number of persons in public institutions for the mentally retarded, including ICF/MR beds and noncertified beds, has decreased by over 50 percent over past 20 years. This decrease in the population of State institutions reflects the trend away from the use of large residential facilities to smaller residences and community-based services. This deinstitutionalization occurred even though the Medicaid program authorized payments to facilities with ICF/MR certification in 1972.

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[25] Lakin, K.C.; B.K. Hill; C.C. White; and E.A. Wright. Medicaid's Intermediate Care Facility for the Mentally Retarded (ICF/MR) Program: An Update (Report No. 25). Minneapolis, University of Minnesota, Department of Educational Psychology, Nov. 1987. p. 21.

2. SERVICES IN NURSING FACILITIES

Some persons with mental retardation or related conditions are served under Medicaid in nursing facilities (ICFs and SNFs) that are not ICFs/MR. According to HCFA, nursing facilities are generally not considered to be appropriate settings for care for persons with mental retardation or related conditions. However, if such an individual has reached the capacity of his or her intellectual and social development or requires primarily skilled medical care, then a nursing facility may be an appropriate setting for care. According to a 1985 nursing home survey, mental retardation was the primary diagnosis at the time of admission for 36,400 nursing home residents.[26] This was approximately 2.4 percent of all nursing home residents.

The Omnibus Budget Reconciliation Act (OBRA87), Public Law 100–203, addresses the issue of inappropriate placements in nursing facilities of persons with mental retardation. Effective January 1, 1989, States are to have in effect a preadmission screening program to determine whether placement in a nursing facility is appropriate for persons with mental retardation. Medicaid reimbursement is not to be made if such placement is found inappropriate. If such placement is found appropriate, States are to determine whether the individual requires active treatment for mental retardation. By April 1, 1990, States must have reviewed all persons with mental retardation already in nursing facilities to determine whether continued placement is appropriate, and must arrange for discharge and active treatment for persons found to be inappropriately placed. To assist States with the transfer to the waiver program of clients placed inappropriately in nursing homes, OBRA87 provided that ICF/MR costs, not the generally lower nursing home costs, could be used in calculating per client expenditures.

B. Home and Community-Based Services Funded Under Medicaid

Medicaid law authorizes DHHS to waive certain Medicaid requirements to allow States to provide a broad range of home and community-based services to individuals who would otherwise require institutional care (section 1915(c)). Home and community-based services available under this waiver may include case management, homemaker/home health aide services, personal care, adult day health, habilitation services, respite care, and other services requested by the State and approved by the Secretary. Other services have included home modifications, nonmedical transportation, nutrition counseling, and congregate and home-delivered meals. (See chapter V; Alternative Delivery Options, for a description of the requirements associated with these waivers.) On June 30, 1986, about 23 thousand persons with mental retardation or related conditions were receiving services under the waiver provision in 33 States.[27]

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[26] Unpublished data from the 1985 National Nursing Home Survey, obtained by phone from Alvin Sirrocco, National Center for Health Statistics, on January 27, 1988.

[27] Lakin, Medicaid's ICF/MR Program, p. 21.

The statute generally leaves the definition of waivered services to State discretion. However, to clarify congressional intent with respect to habilitation services for persons who were previously institutionalized in a Medicaid facility, Public Law 99–272, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), stated that such services include: (1) services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings, and (2) prevocational, educational, and supported employment services. Habilitation services provided under the waiver authority cannot include special education or rehabilitation services available to the individual under other Federal programs.

C. STANDARDS FOR ASSURING QUALITY CARE IN ICFS/MR AND IN COMMUNITY-BASED SERVICES

1. FEDERAL STANDARDS FOR ICFS/MR

Medicaid statute requires ICFs/MR to meet certain definitional requirements as well as standards prescribed by the Secretary for safety and sanitation and for the proper provision of care. Standards were originally published by the Secretary in 1974 and were not significantly revised until the publication of the new regulations on June 3, 1988. The new regulations are intended to increase the focus on the provision of active treatment services to clients, increase self-determination of clients, maintain essential client protections, and provide facility administrators and monitoring agencies with a more accurate mechanism for assessing quality of care. The standards are focused on client and staff performance, although standards regarding facility specifications and health and safety measures are also included. The new regulations are applicable to all sizes of facilities. The effective date of the new regulations is October 3, 1988.

The new regulations establish "conditions of participation" for ICFs/MR, and these are organized into a number of specified areas:

- governing body and management;
- client protections;
- facility staffing;
- active treatment services;
- client behavior and facility practices;
- health care services;
- physical environment;
- dietetic services.

Each condition of participation is composed of a number of standards by which quality can be assessed. All conditions of participation must be met, but institutions will not be decertified if some of the standards within those conditions are not met, if the facility submits an acceptable plan of correction for the deficiencies identified.

States must certify that ICFs/MR meet the conditions of participation before Federal payments may be made for care provided to eligible persons in these institutions. Medicaid law requires the State Medicaid agency to contract with a State survey agency to determine, through inspection, whether facilities meet the Medicaid requirements. In addition, the Secretary of HHS is authorized to "look behind" a State's survey and make an independent determination regarding a facility's compliance with program requirements. The Secretary's determination overrides the States' findings. A facility's participation in Medicaid can be terminated until the deficiencies have been corrected, or a plan of correction has been approved.

If an ICF/MR is found to be substantially out of compliance with program requirements, and if such noncompliance immediately jeopardizes client health and safety, the State is required to terminate the facility's participation in the ICF/MR program. If noncompliance is determined not to pose an immediate threat to health and safety of the clients, the State may refuse payment for services for new clients admitted to the facility after a determination of noncompliance with ICF/MR requirements.

COBRA provided States other options under which ICFs/MR may remedy deficiencies that do not pose an immediate threat to clients' health and safety. These provisions allow the State Medicaid agency to submit written plans either to: (1) make all necessary corrections in such facilities, including staff and physical plant corrections, within 6 months of the approval date of the plan, or (2) to reduce permanently the number of beds in certified units within 36 months of the approval date of the plan while continuing to receive Federal payments. (For further information on enforcement of ICF/MR standards, see chapter VI; Administration.)

2. STANDARDS FOR COMMUNITY-BASED WAIVER SERVICES

For home and community-based services provided under 2176 waivers, regulations issued by HCFA March 13, 1985, require States to provide assurances that necessary safeguards have been taken to protect the health and welfare of the waiver clients. The regulations specify that safeguards include adequate standards for all types of providers that furnish services under the waiver as well as standards for board and care homes where a significant number of SSI recipients are residing or are likely to reside and where home and community-based services may be provided. If the State has licensure or certification requirements for any services or for individuals who furnish these services under the waiver, it must assure HCFA that the standards in the licensure or certification requirements will be met. The preamble to interim regulations on the waiver program pointed out that the regulations do not attempt to define these safeguards or to prescribe how they are to be developed. Rather they leave to the State the responsibility for determining what the necessary safeguards are, to define them or specify how they will be developed and implemented, and to explain how they satisfy the statute. That is, Federal standards under the waiver program are far less definitive than the quality standards for the ICF/MR program.

IV. MAJOR PUBLIC EXPENDITURES FOR SERVICES FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS

A. Discussion of Major Expenditures

Support for services in institutions of 16 beds or more was approximately evenly divided between Federal and State funds in fiscal year 1986: $2.7 billion was State and $2.5 billion was Federal funding, as shown on figure D–2. However, support for community services, including institutions of 15 beds or fewer, was predominantly State funding: $2.7 billion was State and $0.8 billion was Federal funding. Whereas States spent equal amounts for services in the larger institutions and in the community, Federal funding was used primarily for services in the larger institutions. Most of the Federal funding was Medicaid matching payments.

The major sources of funding for residential services and for community-based daytime habilitation and care for persons with mental retardation or related conditions include the Medicaid program, the Social Services Block Grant (SSBG), and State funds, as shown on table D–1.[28] State funds are used to match Federal Medicaid funding (see chapter IX), and additional State resources are used to fund non-Medicaid services including community residential services, daytime habilitation and training programs, case management, and respite care.

In fiscal year 1986, Medicaid funding for ICFs/MR provided the largest amount of support for services for persons with mental retardation or related conditions. Total funding amounted to $5.2 billion, with $2.9 billion Federal and $2.3 billion State funding.[29] Seventy-five percent of these funds were used for residential services in State institutions of 16 beds or more. As previously noted, in the past States used these large institutions as the primary service setting for persons with mental retardation.

While most funding for large institutions was Medicaid, the primary funding source for community services in fiscal year 1986 was non-Medicaid State funds. State funding for these services was approximately $2.2 billion. (These State expenditures are in addition to State funds used to match Medicaid funds for community services.) State non-ICF/MR expenditures support community residential services, daytime prevocational and care programs, respite care, case management, and other services for persons living with their families or in other residential arrangements.[30]

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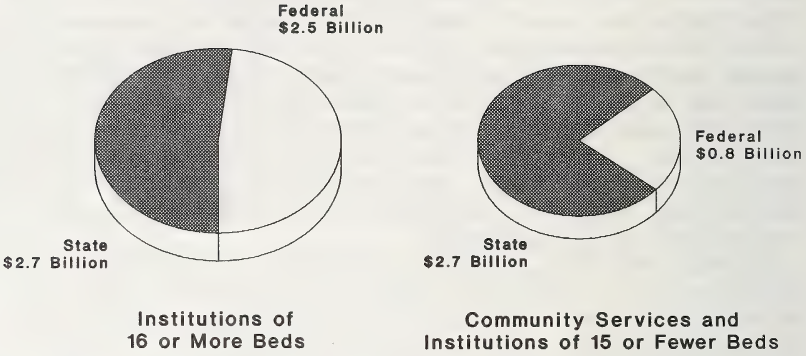
[28] The Social Services Block Grant is authorized under title XX of the Social Security Act.

[29] Braddock, David; Richard Hemp; and Glenn Fujiura. Public Expenditures for Mental Retardation and Developmental Disabilities in the United States: State profiles (2nd edition), Public Policy Analysis Program, University Affiliated Facility for Developmental Disabilities, Institute for the Study of Developmental disabilities, University of Illinois at Chicago, Sept. 19, 1986. Federal ICF/MR expenditures were reported at Braddock at p. 65. State ICF/MR expenditures were calculated by the Congressional Research Service (CRS) as the sum of ICF/MR expenditures by the States and the District of Columbia, which were calculated from the Federal financial participation rates and Federal ICF/MR expenditures reported in Part 3 of Braddock.

[30] Table D–1 includes only the major sources of funds for residential and daytime care for persons with mental retardation or related conditions. It does not include data on other services from which such persons may benefit, but which are supplementary to residential and daytime care for this population, such as special education, vocational rehabilitation, or transportation. Also not included in table D–1 is $3.0 billion in Federal income maintenance payments estimat-

Continued

Figure D-2
Major Federal and State Expenditures for Residential and Community Services for Persons with Mental Retardation or Related Conditions, FY 1986



Source: See Table D-1.

Table D–1.—MAJOR FEDERAL AND STATE EXPENDITURES FOR RESIDENTIAL AND COMMUNITY SERVICES FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS: FISCAL YEAR 1986

[In millions]

	Institutions of 16 beds or more		Community services and ICFs/MR of 15 beds or fewer [1]	Total
	Public	Private		
Medicaid:				
ICF/MR:				
Total	$3,887 (75%)	$624 (12%)	$690 (13%) [2]	$5,201 (100%)
Federal	2,148	356	373	2,877
State	1,739	268	317	2,324
Waiver:				
Total	0	0	261 (100%)	261 (100%)
Federal	0	0	145	145
State	0	0	116	116
Day Programs:				
Total	0	(3)	194 (100%) [3]	194 (100%)
Federal		0	102	102
State		0	92	92
Non-Medicaid:				
Title XX SSBG (Federal)	2 (1%)	0	191 (99%)	193 (100%)
State expenditures	679 (24%)	(4)	2,152 (76%) [4]	2,832 (100%)

[1] Community services includes State and private ICFs/MR of 15 beds or fewer, noncertified community residences, and daytime care and training programs.

[2] Funding in this category is for State and private ICFs/MR of 15 beds or fewer.

[3] A small, but undetermined, amount of these Medicaid funds was used in private institutions of 16 beds or more. Some States have included daytime programs as part of their Medicaid plan.

[4] A small, but undetermined, amount of these State funds were used in private institutions of 16 beds or more.

Source: Braddock, Public Expenditures. Federal ICF/MR expenditures were reported in Braddock at p. 65. State Medicaid matching expenditures were calculated by the CRS as the sum of such expenditures by the States and the District of Columbia, which were calculated from the Federal financial participation rates and Federal Medicaid expenditures reported in Part 3 of Braddock.

As shown in table D–2, States varied significantly in the percentage of their residential care beds that were certified as ICF/MR beds on June 30, 1986. That is, of all beds in residential settings for persons with mental retardation or related conditions, three States had 90 percent or more certified as ICFs/MR: Louisiana, Texas, and Indiana. Four States participating in the ICF/MR program had less than 30 percent of their residential program certified as ICFs/MR: New Hampshire, Montana, Connecticut, and West Virginia. Two States, Arizona and Wyoming, did not participate in the ICF/MR program. Arizona provides only limited Medicaid services under a demonstration waiver, and Wyoming did not include ICF/MR care as a covered service in its Medicaid plan. State variation in the percentage of facilities certified as ICFs/MR reflects the fact that some facilities do not or would not meet Federal standards for participation. Some facilities do not meet ICF/MR standards due to deficiencies in the physical facility, substandard staffing and medical support, or inadequate health and safety provisions. Also, some States use family care, which would not conform to ICF/MR stand-

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ed to be awarded to persons with mental retardation or related conditions who are residing in community settings. (Source: Braddock, Public Expenditures, p. 65.) These income maintenance funds are Federal SSI payments and payments under the Disabled Adult Child program (authorized under title II of the Social Security Act), generally made to persons receiving services in the community. State SSI supplements are also not included in table D–1. (Calculations in tables D–1 and D–2 were done for the Congressional Research Service by Keith Hurt, Technical Information Specialist, Education and Public Welfare Division.)

ards. The ICF/MR standards require a relatively intense level of care, which is considered inappropriate for the needs of mildly and moderately handicapped clients.

Table D–2.—MEDICAID-CERTIFIED ICF/MR BEDS AS A PERCENT OF TOTAL PUBLIC AND PRIVATE RESIDENTIAL CARE BEDS FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS, BY STATE, JUNE 30, 1986

State	Percentage in ICF/MR
Louisiana	92.7
Texas	90.7
Indiana	90.0
SouthCarolina	86.1
Virginia	83.5
Minnesota	82.9
Oklahoma	82.4
Kansas	77.0
Rhode Island	74.5
North Carolina	73.5
Utah	71.9
Ohio	71.7
Arkansas	70.5
Tennessee	70.4
District of Columbia	68.8
Delaware	66.7
Illinois	66.6
New York	65.1
Alabama	62.7
Wisconsin	60.1
Kentucky	60.0
Mississippi	58.6
Georgia	55.8
Oregon	54.7
Pennsylvania	53.6
New Mexico	53.4
North Dakota	52.6
South Dakota	50.2
Maryland	48.6
Washington	47.8
Nevada	46.8
Massachusetts	46.5
Colorado	44.8
NewJersey	43.8
Iowa	43.6
Michigan	42.0
Florida	40.2
Idaho	40.1
Maine	38.3
Vermont	38.2
Nebraska	35.7
Missouri	35.1
California	34.1
Hawaii	33.6
Alaska	33.2
New Hampshire	26.8
Montana	24.7
Connecticut	24.1
West Virginia	19.6

Source: Lakin, K.C.; B.K. Hill; C.C. White; and E.A. Wright. Medicaid's Intermediate Care Facility for the Mentally Retarded (ICF/MR) Program: An Update (Report No. 25). Minneapolis, University of Minnesota, Department of Educational Psychology, Nov. 1987. Table 5. p. 27.

B. MEDICAID FUNDING FOR RESIDENTIAL AND COMMUNITY SERVICES FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS: FISCAL YEARS 1977–86

Between fiscal year 1977 and fiscal year 1986, Medicaid expenditures for persons with mental retardation or related conditions increased from $1.1 billion to $5.7 billion, (see figure D–3). Most of this funding was used for services in large public ICFs/MR. However, the highest rate of growth took place in private facilities. (Growth in private facilities was the result of the transfer of persons out of large State institutions and into private ICFs/MR.)

Over this period there was substantial growth in large State ICF/MR funding as a result of increasing certification of State institutions as ICFs/MR and increasing expenditures per person. However, since fiscal year 1981 the movement of individuals out of large State institutions has resulted in two trends: (1) a reduction in the growth of expenditures in large State ICFs/MR, and (2) an increase in expenditures for large and small private ICFs/MR. Individuals have been transferred out of large State institutions and into large and small private facilities. If this trend continues, ICF/MR funds could be expected to be used increasingly in private facilities of all sizes as the populations of large State institutions declines. In fiscal year 1987, 40 to 44 percent of the residents of private ICFs/MR were in for-profit facilities.[31]

Waiver expenditures (Federal and State) have increased from $2.2 million in fiscal year 1982 to $261.8 million in fiscal year 1986. Although this shows significant growth over this period, the waiver program funds a relatively small part of the population of persons with mental retardation or related conditions who are eligible for Medicaid. Also, the requirement that average per capita waiver costs cannot exceed anticipated ICF/MR costs tends to limit broad use of the waiver as a major source of funding for community-based services.

Figure D–4 shows selected Medicaid expenditures for persons with mental retardation or related conditions by program type as a proportion of all Medicaid dollars allocated for these programs.[32] This presentation shows that, while overall Medicaid outlays were increasing, support for large State ICFs/MR decreased from 93 percent of the total in fiscal year 1977 to 69 percent of the total in fiscal year 1986. During this period, Medicaid support in other service settings increased as a proportion of these Medicaid dollars. The most notable growth was in private institutions of 15 beds or fewer, which increased from 1.6 percent of these funds in fiscal year 1977 to 10.3 percent of these funds in fiscal year 1986. The least utilized service supported by these Medicaid funds was State facilities of 15 beds or fewer. These data partly reflect a State preference to contract with the private sector for delivery of ICF/MR services rather than maintain or expand services in large State institutions or establish small State-operated ICFs/MR.

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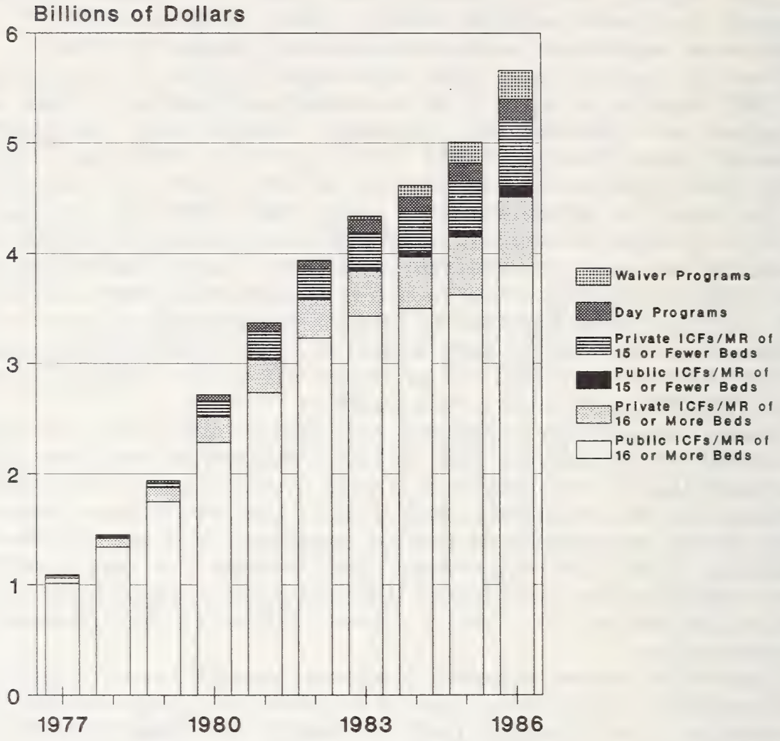
[31] Estimate obtained by telephone from K.C. Lakin on July 29, 1988.

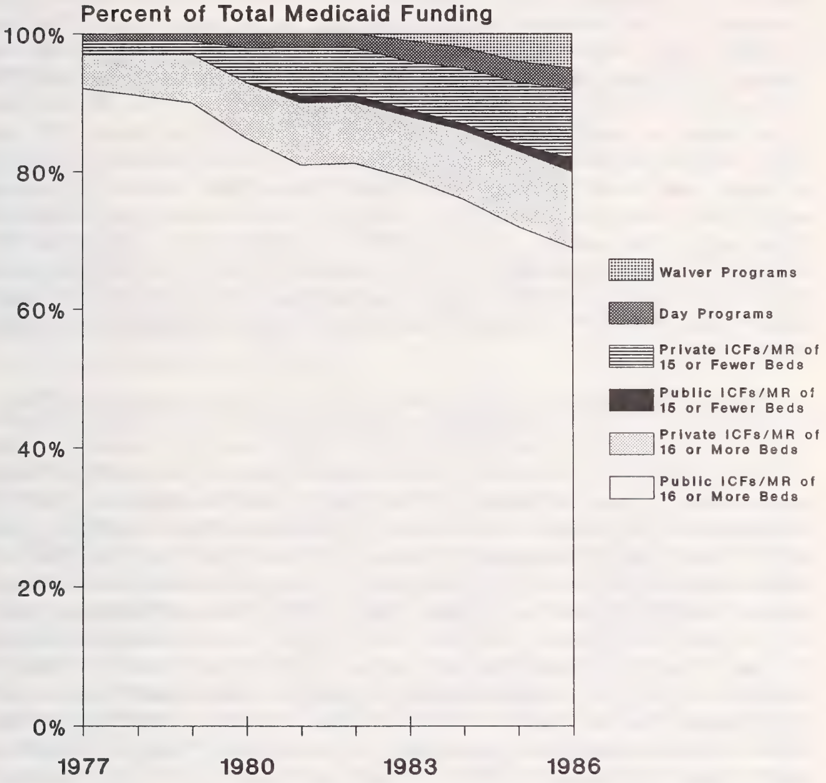
[32] Expenditures are for services specifically for persons with mental retardation or related conditions. This presentation excludes Medicaid funding for health services provided to persons who are not in community waivers or ICFs/MR.

Figure D-3
Total Medicaid Funding for Services for Persons with Mental Retardation and Related Conditions, 1977-1986



Source: Congressional Research Service analysis of data from the Institute for the Study of Developmental Disabilities, University of Illinois at Chicago.

Figure D-4
Allocation of Medicaid Funding for Persons with Mental Retardation and Related Conditions, 1977-1986



Source: Congressional Research Service analysis of data from the Institute for the Study of Developmental Disabilities, University of Illinois at Chicago.

C. NUMBERS OF RESIDENT IN ICFs/MR: 1977 TO 1986

The number of persons residing in ICFs/MR increased from 106,166 on June 30, 1977 to 143,815 on June 30, 1986, an increase of 35 percent over the decade, as shown on figure D–5. However, most of this growth occurred between June 30, 1977 and June 30, 1982. Between June, 30, 1982 and June 30, 1986, the number of ICF/MR residents increased only 2 percent. Two factors influenced these changes: (1) the increase in the certification of institutional beds as ICF/MR beds (especially between 1977 and 1982), and (2) the decrease in the number of persons in large State institutions between 1977 and 1986. Major trends in persons served in ICFs/MR include a decrease in residents of large State ICFs/MR between 1977 and 1986, which coincided with an increase in the number of residents in large and small private ICFs/MR during this period. These demographic changes generally correspond to the changes in expenditures examined above. The number of residents in large private ICFs/MR nearly tripled over the decade (11,958 to 31,945 persons), while the number of residents in small private ICFs/MR increased from 1,354 to 17,930 persons, the fastest rate of growth of all types of facilities.

D. ICF/MR SERVICES, PERSONS SERVED, AND ESTIMATES OF PER DIEM EXPENDITURES

In fiscal year 1986, most ICF/MR funding went to large State-operated facilities. As noted above, most institutionalized persons with mental retardation or related conditions were served in these large State facilities. Large private facilities receiving ICF/MR reimbursements served only one-third as many institutionalized persons as large State institutions. The highest cost per person was in large State institutions and the lowest cost was in large private facilities. State-operated institutions of 16 beds or more served the largest number of institutionalized persons. Such institutions used 75 percent ($3.9 billion) of the ICF/MR funding to serve 63 percent of the institutionalized population. Private facilities of 16 beds or more used 12 percent ($629 million) of the ICF/MR funding to serve 22 percent of the institutionalized population. Most persons served in ICFs/MR of 15 beds or fewer were served in private facilities. Table D–3 shows these data in detail.

The most costly service per client ($42,812 per year) was delivered in State-operated ICFs/MR of 16 or more beds, and the least costly service ($19,690 per year) was delivered in private ICFs/MR of 16 or more beds. A major contributing factor to the high cost of services in large State ICFs/MR was that persons with the most severe disabilities, who may also have the most severe behavior problems, and therefore require very intensive services, tend to be served in State institutions. For example, in fiscal year 1985, 58 percent of the disabled persons in large State ICFs/MR were profoundly retarded, while only 30 percent of the disabled persons in large private ICFs/MR were profoundly retarded.[33] Data for 1982

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[33] Data on client characteristics were obtained by telephone from K.C. Lakin on Jan. 15, 1988.

Table D–3.—FEDERAL AND STATE ICF/MR FUNDING AND PERSONS SERVED, BY FACILITY SIZE AND OWNERSHIP, FISCAL YEAR 1986

ICF/MR Payments: Fiscal Year 1986 [1] (in millions of dollars)	Persons served on June 30, 1986	Per person/ per year expenditure [2]
FACILITIES OF 16 BEDS OR MORE		
Public $3,895 (75%)	Public 90,980 (63%)	$42,812
Private 629 (12%)	Private 31,945 (22%)	19,690
Subtotal 4,524 (87%)	122,925 (85%)	....
FACILITIES OF 15 BEDS OR FEWER		
Public 105 (2%)	Public 2,960 (2%)	35,473
Private 586 (11%)	Private 17,930 (13%)	32,683
Subtotal 691 (13%)	20,890 (15%)	....
Total $5,215 (100%)	143,815 (100%)	....

[1] Expenditures shown are the sum of Federal and State ICF/MR expenditures. Federal ICF/MR expenditures are reported in Braddock at p. 65. State ICF/MR expenditures were calculated by CRS as the sum of ICF/MR expenditures by the States and the District of Columbia, which were calculated from the Federal participation rates and Federal ICF/MR expenditures reported in Part 3 of Braddock.

[2] These estimates were calculated by the CRS by dividing expenditures for fiscal year 1986 by the number of persons served on June 30, 1986. These estimates assume constant length of stay across all institution types.

Source: Braddock, Public Expenditures, and Lakin, ICF/MR Program, p. 21.

indicate that 60 percent of the persons in large State ICFs/MR were not toilet trained, while only 16 percent of the persons in private ICFs/MR of 16 beds or more were not toilet trained.[34]

Another major factor contributing to increased costs in large State facilities was that employee unions were more prevalent in the larger State facilities than in private facilities, and ICF/MR services are labor-intensive. Unionized employees in State institutions generally have higher wages and benefits than their nonunionized counterparts.

Costs of services in State and private ICFs/MR of 15 beds or fewer were generally comparable at $35,473 per year in State facilities and $32,683 per year in private facilities. These smaller facilities tend to serve persons who are more severely disabled than those served in large private facilities. Persons served in the smaller facilities tend to be individuals who have previously been served in large State institutions. Also, many of the smaller facilities tend to be new, or newly purchased, and are located in urban or suburban areas where real estate values are high. The larger private institutions are generally older facilities located in rural areas and have lower facility and personnel costs.[35]

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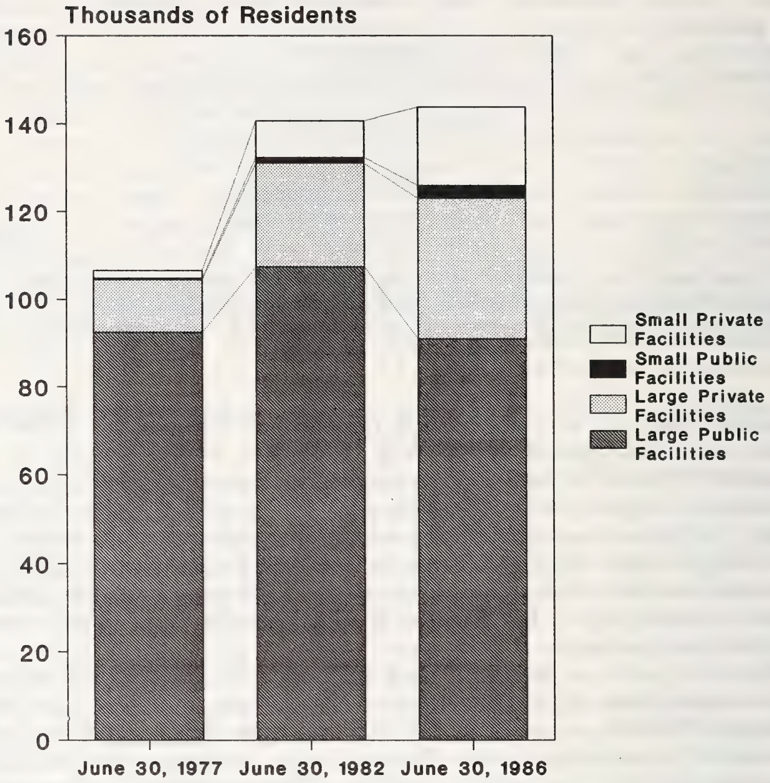
[34] *Ibid.*

[35] Studies are not available to show comparisons between ICF/MR costs and the cost of State-funded community-based services, which include residential services as well as daytime services for disabled persons living with their families. However, a major study comparing institutional costs and community residential costs indicated that on average, institutional costs were higher per client day for a group of clients matched for adaptive behavior, age, and medical need. This study found that per diem costs of community residential programs were approximately 70 percent of the cost of institutional services due, in large part, to lower staff salaries and fringe benefits in the community settings. If personnel costs were equal in both settings, per diem rates would be equivalent, according to this study. However, clients in community residential settings received more staff time per client than clients in institutions. Source: Conroy, J., and Bradley, V., The Pennhurst Longitudinal Study: Combined Report of Five Years of Research and Analysis. Human Services Research Institute, Boston, Mass. March 1, 1985, p. 219–244.

Figure D-5
ICF/MR Residents by Size and Type of Facility



Source: K. Charlie Lakin, et. al., Medicaid's Intermediate Care Facility for the Mentally Retarded (ICF-MR) Program: An Update. Figure prepared by Congressional Research Service.

On June 30, 1986, the average size of a State-operated ICF/MR was 327 beds, and the average size of a private ICF/MR was 62 beds. On June 30, 1985, the largest State ICF/MR had 1,351 residents, and 6 percent of the State facilities had 1,000 residents or more. On that date, only 1 percent of the private ICFs/MR had more than 300 residents.[36] On June 30, 1986, there were a total of 2,889 private ICFs/MR and 576 public ICFs/MR of all sizes.[37]

As shown in table D–4, data for fiscal year 1985 indicate that States vary significantly in the per diem expenditure for ICF/MR services, ranging from a high of $145 per day in the District of Columbia to a low of $40 per day in Kansas and Oklahoma.

Table D–4.—AVERAGE MEDICAID PAYMENT PER PATIENT DAY FOR ICF/MR SERVICES, STATES RANKED BY FISCAL YEAR 1985 PER DIEM

State	Per diem
District of Columbia	$145
Nevada	132
Massachusetts	126
Rhode Island	114
North Carolina	110
Georgia	107
Vermont	104
Florida	102
Pennsylvania	100
Maryland	99
Maine	98
Missouri	97
Kentucky	94
New Mexico	90
Arkansas	89
Iowa	89
Idaho	86
Colorado	85
Virginia	83
Nebraska	78
Oregon	78
Illinois	77
Tennessee	73
Minnesota	72
Ohio	70
Louisiana	68
South Dakota	64
Wisconsin	61
Michigan	52
Mississippi	49
California	44
Texas	48
Indiana	44
West Virginia	41
Kansas	40
Oklahoma	40

Note: Data on States not included in this table were not reported or were not available.

Source: Health Care Financing Administration. Health Care Financing Program Administration Analysis of State Medicaid Program Characteristics, 1986. Table 51, p. 93.

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[36] Data on client characteristics were obrained by telephone from K.C. Lakin on Jan. 15, 1988.

[37] Lakin, Medicaid/s ICF/MR Program, p. 21.

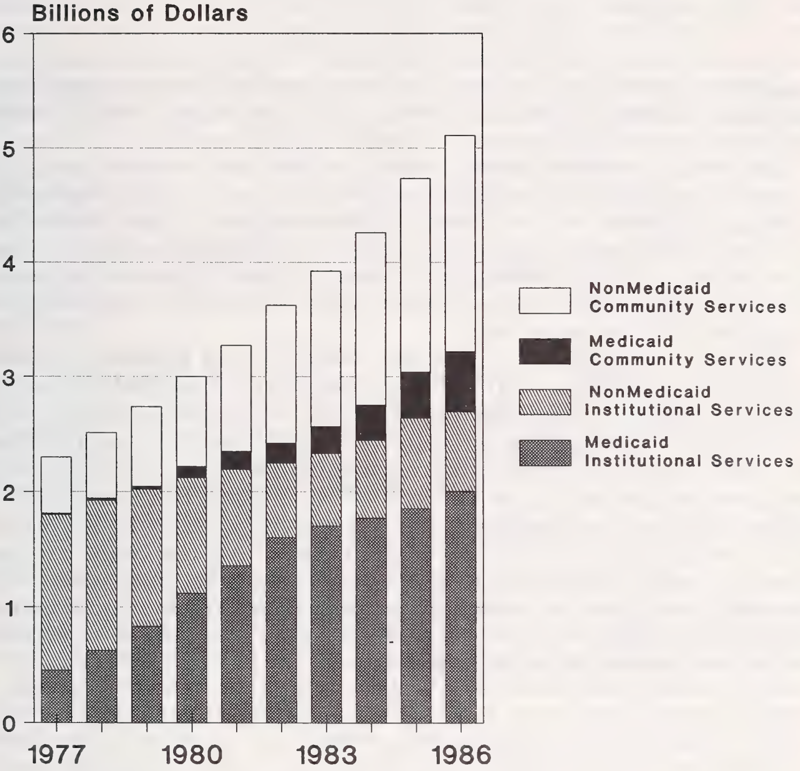
E. STATE FUNDING FOR SERVICES FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS: FISCAL YEARS 1977–86

State funding for services to this population is composed of State funds used to match Federal Medicaid funds and additional State funds, most of which are used for community-based services. Total State funding of services for persons with mental retardation or related conditions increased from $2.3 billion in fiscal year 1977 to $5.1 billion in fiscal year 1986, as shown on figure D–6.

The largest increase in State expenditures was funding for non-Medicaid community services, which increased from $484 million in fiscal year 1977 to $1.9 billion in fiscal year 1986. This increase reflects State initiatives to expand community-based services and thereby offer alternatives to institutionalization. State funds for non-Medicaid community services in fiscal year 1986 were over three times the amount used to match Federal Medicaid funding used for community services in that year.

The increases in State funding of non-Medicaid community services can be seen as a response to: (1) the need for alternatives to institutionalization, (2) the need for support services for families wishing to keep disabled persons at or near home, and (3) the recognition that community services can facilitate increased independence and productivity of persons with mental retardation or related conditions.

Figure D-6
State Funding for Services for Persons with Mental Retardation and Related Conditions, 1977-1986



Source: Congressional Research Service analysis of data from the Institute for the Study of Developmental Disabilities, University of Illinois at Chicago.

F. NOTES ON EXPENDITURE DATA FOUND IN TABLE D–1

Data on Federal expenditures were obtained from David Braddock, Richard Hemp and Glenn Fujiura, *Public Expenditures for Mental Retardation and Developmental Disabilities in the United States,* 2nd edition, Public Policy Analysis Program, University of Illinois at Chicago, Sept. 19, 1986, p. 65. All estimates were prepared by the Congressional Research Service. Federal Medicaid ICF/MR program expenditures for community services were calculated as the sum of Federal ICF/MR program expenditures for public and private facilities of less than 16 beds. State Medicaid expenditures are based on the Federal financial participation rates (adjusted Federal Medical Assistance Percentages) and Federal Medicaid expenditures reported in Part 3 of Braddock.

All Federal expenditures under the Medicaid waiver programs reported by Braddock et al. have been assigned to the community services category, as are matching State expenditures. While Federal and State matching expenditures for Medicaid day programs have been assigned to community services, an undetermined share of these expenditures may finance services provided in private institutions of 16 or more beds.

State non-Medicaid expenditures used to fund services provided in public institutions of 16 or more beds are calculated as the difference between total State expenditures on these institutions and the amount calculated to be State Medicaid matching expenditures for these institutions. State expenditures not used to finance services provided in public institutions of 16 or more beds are calculated as total State expenditures for services other than those provided in public institutions of 16 or more beds, less the State SSI supplement and all State Medicaid matching expenditures. This amount is assigned to community services. An undetermined share of these expenditures may be used to finance provision of services in private institution of 16 or more beds.

APPENDIX E. MEDICAID SERVICES FOR THE MENTALLY ILL [1]

I. INTRODUCTION

Medicaid is an important source of funding for the treatment of mental illness, including both chronic mental illness and short-term acute problems. In fiscal year 1986, over $1.1 billion in Medicaid funds went to mental institutions, while additional funds were spent on services for mental illness in ordinary hospitals and nursing homes and in the community.[2] However, the mentally ill have never emerged, as the mentally retarded have, as a distinct population served by the Medicaid program. Medicaid provides some services to some segments of the mentally ill population under certain conditions.

The limitations on Medicaid's role are due in part to specific policy decisions made in the early years of the program and in part to the nature of the mentally ill population. This population is heterogeneous and ill-defined, with widely differing problems and needs. Before discussing Medicaid's role, then, it is necessary to define the population under consideration.

A. Defining the Mentally Ill Population

Broadly speaking, the "mentally ill population" at any given time consists of all persons who, at that point in time, have been or could be diagnosed as suffering from one of a variety of defined mental disorders. Some of these persons are experiencing moderate problems that are of recent origin and that may never recur. Others have severe problems that have continued over a long period and that may be expected to continue in the future. The latter, often called the "chronically mentally ill," may be thought of as constituting a distinct population and are what are usually meant when people speak of the mentally ill. As used in this appendix, the term mentally ill will generally be used to mean the chronically mentally ill, and will exclude persons whose primary diagnosis is mental retardation.

Even the definition of the chronically mentally ill has been the subject of some disagreement. Some definitions focus on the extent to which individuals are impaired in daily functioning or on the duration of their illness. Others rely on a history of recent or repeated institutionalization.

The discussion in this appendix will follow the classifications used by the National Institute of Mental Health (NIMH) for the purpose of estimating the size of the chronically mentally ill population. NIMH divides the chronically mentally ill into institutional residents and community residents. The institutional residents are those who have been in a mental hospital for more than 1 year or who are in a nursing home with a diagnosed mental condition (including simple senility).[3] The community residents are those with mental illness who may be deemed disabled according to several different criteria, including inability to work, history of hospitalization, or certification for Social Security or Supplemental Security Income disability benefits.[4]

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[1] This chapter was written by Mark Merlis.

[2] Medicaid data do not distinguish expenditures for treatment of mental as opposed to physical problems by providers other than mental institutions.

Using these criteria, NIMH estimated that there were 1,700,000 "severely disabled" chronically mentally ill persons in 1975–77, and another 700,000 "moderately disabled" persons. (The estimate is for a range of years rather than a single point in time because the data are derived from several different sources.) Of the severely disabled, 900,000 were in institutions. 750,000 of these persons were in nursing homes, while the rest were in public and private mental or psychiatric hospitals, Veterans Administration facilities, residential treatment centers, or community mental health centers.[5]

One population of particular concern is the chronically mentally ill who are homeless. It has been estimated that 20 to 40 percent of the homeless are chronically mentally ill. Estimates of the total number of homeless people range from one-quarter of a million to three million. Given this range, it is impossible to reasonably estimate the number of homeless mentally ill people. Although "deinstitutionalization," the discharge of mentally ill persons from State institutions, has sometimes been spoken of as a major factor in homelessness, recent estimates suggest that relatively few of the homeless are actually former residents of mental hospitals. Some observers now speak instead of "noninstitutionalization," the failure to provide residential treatment to persons who need it.[6]

B. MEDICAID ELIGIBILITY FOR THE MENTALLY ILL

Medicaid has no special eligibility rules or conditions for the mentally ill. Those in the community may qualify by receiving SSI disability benefits or by meeting medically needy standards in the States with medically needy programs. Those in institutions may qualify because they have no financial resources or because they "spend down," and thereby meet eligibility standards after contributing to the cost of their own care.

The number of mentally ill Medicaid beneficiaries living in the community cannot be firmly established. However, the Social Security Administration estimates that, of 1.6 million persons receiving SSI disability payments in December 1986, 26.5 percent, or about 425,000, had a primary disability of mental illness (other than mental retardation).[7] As only about 5 percent of all SSI disability beneficiaries are in institutions at any given time, the vast majority of these mentally ill SSI beneficiaries must have been living in the community or in settings such as board and care homes or halfway houses. Most of these persons would automatically have qualified for Medicaid. Other mentally ill persons may have qualified for Medicaid through other assistance categories.

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[3] The reasons for, and problems with, including senility as a mental illness will be discussed below.

[4] Goldman, Howard H., and Ronald W. Manderscheid. Chronic Mental Disorder in the United States, in National Institute of Mental Health. Mental Health, United States, 1987. Rockville, Md. 1987. DHHS Pub. No. (ADM)87–1518. p. 5.

[5] Goldman and Manderscheid, p. 13.

[6] U.S. Congress. Congressional Research Service. Homelessness: Issues and Legislation in 1988, by Ruth Wasem. CRS Issue Brief IB88070. [Regularly updated]

The number of persons receiving Medicaid-covered services in mental institutions during fiscal year 1986 was 51,795. Data from the 1985 National Nursing Home Survey indicate that an additional 149,811 mentally ill persons were receiving Medicaid nursing home services. (Further details on the institutional population appear in Part II of this appendix.) At any given time, then, the Medicaid program may be covering about 200,000 mentally ill persons in institutions and twice that number in the community.

As will be discussed further in Part II of this appendix, Medicaid does not cover services in mental institutions for persons between age 21 and age 65. A person in this age group who is in an excluded institution may not receive Medicaid benefits, regardless of his or her financial needs. This means that some persons who were eligible for Medicaid in the community lose eligibility when they enter an institution. If they then return to the community, there may be delays or problems in restoring eligibility. As a result, some persons may fail to receive outpatient follow-up care.

Congress has taken some steps to facilitate Medicaid eligibility for the homeless. The Omnibus Budget Reconciliation Act of 1986 (OBRA86, Public Law 99–509) provided that eligibility could not be denied on the grounds that an applicant had no fixed address. The Omnibus Budget Reconciliation Act of 1987 (OBRA87, Public Law 100–203) requires States to develop systems to ensure that homeless Medicaid beneficiaries receive Medicaid identification cards.

C. TYPES OF SERVICES FOR MENTAL ILLNESS

Federal and State Medicaid policies have distinguished among three classes of services for mental illness, each subject to its own rules:

- Services provided by a distinct set of *mental health providers,* such as institutions for mental diseases (IMDs), inpatient psychiatric hospitals, mental health clinics, and mental health professionals such as clinical psychologists;
- *Mental health services* furnished by types of providers who also treat physical problems; the State might, for example, define a service called "psychotherapy," which could be furnished by any participating physician;
- General health services that happen in some cases to be furnished to a patient with a *diagnosis of mental illness.* If a patient is admitted to an acute general hospital with a psychiatric diagnosis, the patient is receiving ordinary inpatient hospital services, not inpatient psychiatric hospital services.

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[7] The estimate omits the 304,000 SSI disability recipients who were transferred from the predecessor Aid to the Permanently and Totally Disabled (APTD) program in 1973 and who were still receiving benefits in 1986.

The boundaries between the three classes of services have not always been clear; the distinctions may seem almost semantic. As will be seen, however, the use of these distinctions is a central theme in Medicaid policy regarding services for the mentally ill. The assignment of any particular service to one of the three groups may determine whether it will be covered under Medicaid and how it will be reimbursed.

This appendix provides a brief overview of Medicaid's role in two areas: the financing of long-term care in institutions, and the provision of short-term care through community-based providers. The discussion concludes with a look at efforts to improve the coordination of services for the chronically mentally ill in the community.

It should be noted that some of the statistics cited in this appendix relating to treatment of mental illness include treatment for alcoholism or drug abuse. So far as possible, services for the mentally retarded have been excluded. These services are discussed in Appendix D.

II. INSTITUTIONAL SERVICES

State Medicaid programs may, at their option, cover services in two types of institutional mental health providers: "institutions for mental diseases," or IMDs, and inpatient psychiatric hospitals. Services in IMDs may be covered only for beneficiaries aged 65 and older. Services in inpatient psychiatric hospitals may be covered only for beneficiaries under age 21. Beneficiaries who are under 21 at the time they enter such a facility may continue receiving care until they reach age 22. Table E–1 shows the number of States providing each type of service as of October 1987. Table E–2 shows, by State, beneficiaries and payments for each type of service.

The effect of the rules for the two types of institutional mental health providers is to exclude Medicaid coverage of services in mental institutions for persons between 21 and 65 years old. This exclusion is sometimes described as representing a broad policy decision that the Federal Government would not assume overall responsibility for the care of the mentally ill, but would leave this responsibility with the States. However, the legislative history of the exclusions does not conclusively indicate that they stem from any abstract principles about appropriate Federal and State roles.

Optional Medicaid coverage of services in mental institutions for persons over 65 was included in the original 1965 Medicaid legislation, reversing an exclusion of coverage for such services in the precursor Kerr-Mills program of medical assistance for the low-income aged. The option of covering services for persons aged 21 and under in psychiatric hospitals was provided by the Social Security Amendments of 1972. The new coverage, which did not appear in the House bill, was added by the Senate Finance Committee. The Committee report declared that helping mentally ill children become functional members of society was an appropriate use of Medicaid funds, and indicated that further study was necessary to resolve the question of whether it would also be appropriate to extend Medicaid coverage to institutional services for persons aged 21 to 65.

As of 1972, then, the issue of the Federal role in the treatment of the mentally ill was still open. At the same time, however, there was increasing congressional concern that the cost of the Medicaid program had so far exceeded the original 1965 projections. Medicaid legislation in ensuing years focussed on cost containment. The continued exclusion of the 21 to 65 age group may therefore have represented a response to budgetary constraints, rather than a deliberate policy.

The mentally ill aged 21 to 65 could receive Medicaid services in facilities that did not specialize in mental health care, such as ordinary nursing homes. Concerns about the adequacy of the care received by the medically ill in these facilities, and about difficulties in distinguishing between IMDs and nursing homes that happen to have mentally ill residents, have emerged as major issues in Medicaid policy for the mentally ill.

Table E-1.—STATE COVERAGE OF MENTAL HEALTH SERVICES, 1987

	Number of States Providing Coverage
Institutions for mental diseases (IMDs) for persons over age 65:	
Inpatient hospital, skilled nursing facility (SNF), and intermediate care facility (ICF)	23
Inpatient hospital and ICF	4
Inpatient hospital only	15
ICF and SNF only	1
ICF only	1
Inpatient psychiatric hospitals for persons under age 21	28

Source: Health Care Financing Administration. Medicaid Services, State by State. Baltimore. October 1987. HCFA Pub. No. 02155–88.

Table E-2.—MEDICAID BENEFICIARIES AND PAYMENTS FOR INSTITUTIONAL MENTAL HEALTH SERVICES, FISCAL YEAR 1986

[All payments are in thousands of dollars]

State	Institutions for mental diseases for persons aged 65 and over				Inpatient psychiatric services for those age 21 and under		Institutional mental health services total	
	Inpatient hospital level		SNF/ICF level					
	Beneficiaries	Payments	Beneficiaries	Payments	Beneficiaries	Payments	Beneficiaries	Payments
Alabama	0	0	0	0	301	2,475	301	2,475
Alaska	0	0	100	233	0	0	100	233
Arkansas	149	578	477	13,192	0	0	626	13,770
California	80	398	360	10,715	140	1,619	580	12,732
Colorado	19	201	499	7,661	0	0	518	7,862
Connecticut	693	17,050	502	11,133	0	0	1,195	28,183
Delaware	6	129	0	0	73	1,966	79	2,094
District of Columbia	356	14,459	212	1,671	0	0	568	16,130
Florida	277	7,983	0	0	0	0	277	7,983
Georgia	0	0	0	0	0	0	0	0
Hawaii	0	0	0	0	0	0	0	0
Idaho	0	0	0	0	0	0	0	0
Illinois	338	2,623	1,416	8,585	55	120	1,809	11,328
Indiana	93	1,243	423	4,348	0	0	516	5,591
Iowa	117	718	415	2,567	0	0	532	3,285
Kansas	90	1,271	917	9,073	0	0	1,007	10,344
Kentucky	180	1,105	689	9,454	0	0	869	10,559
Louisiana	43	504	715	12,217	0	0	758	12,721

Table E–2.—MEDICAID BENEFICIARIES AND PAYMENTS FOR INSTITUTIONAL MENTAL HEALTH SERVICES, FISCAL YEAR 1986—Continued

[All payments are in thousands of dollars]

State	Institutions for mental diseases for persons aged 65 and over				Inpatient psychiatric services for those age 21 and under		Institutional mental health services total	
	Inpatient hospital level		SNF/ICF level					
	Beneficiaries	Payments	Beneficiaries	Payments	Beneficiaries	Payments	Beneficiaries	Payments
Maine	0	0	0	0	0	0	0	0
Maryland	647	20,201	0	0	44	1,556	691	21,757
Massachusetts	176	6,373	10	117	0	0	186	6,490
Michigan	229	1,236	2,704	50,312	101	1,487	3,034	53,035
Minnesota	575	13,095	0	0	0	0	575	13,095
Mississippi	0	0	0	0	0	0	0	0
Missouri	335	5,605	401	1,258	0	0	736	6,864
Montana	0	0	0	0	0	0	0	0
Nebraska	76	1,221	150	1,702	0	0	226	2,923
Nevada	14	110	2	27	0	0	16	137
New Hampshire	2	18	0	0	189	4,670	191	4,688
New Jersey	1,007	38,582	827	21,574	0	0	1,834	60,155
New Mexico	0	0	0	0	0	0	0	0
New York	11,566	445,963	5,014	85,433	1,105	11,419	17,685	542,816
North Carolina	686	6,630	771	11,951	0	0	1,457	18,582
North Dakota	141	2,766	69	587	0	0	210	3,353
Ohio	440	7,514	478	5,755	0	0	918	13,269
Oklahoma	78	1,457	867	17,013	0	0	945	18,469
Oregon	136	1,400	306	4,530	0	0	442	5,930
Pennsylvania	1,890	48,203	3,945	52,225	0	0	5,835	100,428
Rhode Island	51	1,030	0	0	0	0	51	1,030
South Carolina	845	3,163	116	564	280	5,404	1,241	9,131
South Dakota	0	0	0	0	114	2,611	114	2,611
Tennessee	336	140	1,731	21,449	281	1,714	2,348	23,303
Texas	5	35	0	0	0	0	5	35
Utah	36	986	129	4,125	0	0	165	5,111
Vermont	25	601	9	90	0	0	34	690
Virginia	52	71	0	0	1,064	27,659	1,116	27,730
Washington	550	7,349	120	2,298	0	0	670	9,647
West Virginia	0	0	74	253	0	0	74	253
Wisconsin	187	792	1,059	13,295	0	0	1,246	14,087
Wyoming	15	252	0	0	0	0	15	252
Total	22,541	663,055	25,507	385,407	3,747	62,701	51,795	1,111,163

Source: HCFA form 2082.

A. INSTITUTIONS FOR MENTAL DISEASE

IMD services may be provided at the inpatient hospital, skilled nursing facility (SNF), or intermediate care facility (ICF) level. Until 1988, the Medicaid statute did not make clear what distinguished an IMD from an ordinary hospital, SNF, or ICF. The Medicare Catastrophic Coverage Act of 1988 (Public Law 100–360), defines an IMD as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services." This definition follows the one already contained in Medicaid regulations, with one addition, the lower limit of 16 beds. This limit means that persons between 21 and 65 in group homes and other small residential facilities may receive Medicaid benefits for physician, clinic, or other services they may require; Medicaid will still not pay the costs of room and board in the facility.

Medicaid regulations indicate that the classification of an institution as an IMD, rather than as an ordinary provider, "is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such." (42 CFR 435.1009) As will be discussed in section C, the determination of a facility's "overall character" has been a source of controversy between the Federal Government and the States.

B. Psychiatric Hospitals

The definition of an inpatient psychiatric hospital is more clearcut than the definition of an IMD. A psychiatric hospital must meet Medicare conditions of participation. Prior to 1984, this meant that it had to be specifically certified as a psychiatric facility by the Joint Commission on Accreditation of Hospitals. The requirement was deleted from Medicare law by the Deficit Reduction Act of 1984 (Public Law 98–369), but has been retained in Medicaid regulations. Beneficiaries receiving inpatient psychiatric hospital services must be undergoing active treatment, in accordance with an individual plan of care, intended to "improve the recipient's condition or prevent further regression so that the services will no longer be needed." (42 CFR 441.150) The nature of the care may therefore be different from that provided in IMDs, some of whose patients might receive essentially custodial care.

C. Services for Mental Illness in Other Types of Facilities

Beneficiaries between age 22 and age 65 may receive services for mental illness in hospitals and nursing facilities, but only if those facilities are not IMDs or psychiatric hospitals. A beneficiary in this age group could be admitted to an acute general hospital with a diagnosis of mental illness, or could enter a nursing home that was not classed as an IMD. The distinction between a nursing facility that is an IMD and a facility that merely happens to be treating a number of mentally ill patients has been a source of contention between HCFA and the States. HCFA has contended that Medicaid programs are reimbursing, as SNF or ICF services, care that is actually being furnished by IMDs. As a result, HCFA argues, some States are improperly claiming Federal funds for IMD services provided to beneficiaries between age 22 and age 65. The dispute has centered on the issue of determining whether the "overall character" of a facility is that of an IMD.

The dispute has its roots in the earliest years of the Medicaid program. Medicaid was enacted in 1965, during the same period that saw a national movement to deinstitutionalize chronic mentally ill persons who could be treated in the community. The number of patients in State mental institutions went from 559,000 in 1955 to 114,000 in 1984.[8] Although there is a common perception that the patients released from mental institutions went directly into the community, some did not. Instead, they were "transinstitutionalized," transferred from State hospitals to nursing homes. One study estimated that 25 percent of the total growth in the nursing home industry between 1960 and 1970 was attributable to the substitution of nursing home services for services in mental hospitals.[9] Many of the patients shifted during this period may have been aged; a 1971 study reported that 40 percent of persons over age 65 discharged from State mental hospitals in 1969 were transferred to nursing homes.[10] However, some observers have noted that States would also have had a financial incentive to transfer younger patients from State hospitals, where Medicaid funds were unavailable, to non-IMD nursing homes, where the same patients could receive Medicaid coverage.

Although the era of "transinstitutionalization" is over, a considerable number of mentally ill persons are being treated in nursing homes. Table E–3 gives data on the primary diagnoses of Medicaid and non-Medicaid population in nursing homes in 1985, as estimated from the 1985 National Nursing Home Survey. Overall, 29 percent of nursing home residents under age 65, and 17 percent of those over 65, had a primary diagnosis of mental illness. Among the residents under 65, Medicaid beneficiaries were less likely than other residents to have a diagnosis of mental illness; the reverse is true for those over 65. Among the mentally ill residents over 65, 77 percent had a primary diagnosis of dementia, which includes Alzheimer's disease and other conditions that result from physical damage to or deterioration of the brain. (The survey sample of mentally ill residents below age 65 was too small to permit reliable estimates of the percentage with dementia.)

The presence of large numbers of mentally ill Medicaid beneficiaries in facilities classified as ordinary nursing homes has raised two major issues. The first is whether some facilities that are actually IMDs have been classified as SNFs or ICFs, possibly in order to circumvent the exclusion of Medicaid coverage for persons aged 21 to 65 in IMDs. The second, complementary question is whether mentally ill persons in facilities that do not specialize in the treatment of mental illness are receiving the care they need.

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[8] National Institute of Mental Health estimate, cited in Intergovernmental Health Policy Project, Report on Issues of Policy: The Mentally Ill in Nursing Homes. State Health Reports: Mental Health, Alcoholism, and Drug Abuse, No. 25, July 1986.

[9] Hawes, Catherine, and Charles D. Phillips. The Changing Structure of the Nursing Home Industry and the Impact of Ownership on Quality, Cost, and Access. In: For Profit Enterprise in Health Care, Institute of Medicine, National Academy of Sciences, Bradford Gray ed. Washington 1986. p. 492–541.

[10] Cited, Intergovernmental Health Policy Project, p. 2.

Table E-3.—NURSING HOME RESIDENTS BY PRIMARY DIAGNOSIS AND SOURCE OF PAYMENT, 1985

	Source of Payment			Total
	Medicaid SNF	Medicaid ICF	Other	
Residents under age 65:				
Total	38,895	63,094	70,739	172,728
Mental illness, all types	9,271	14,316	26,454	50,041
Percent, mentally ill	23.8	22.7	37.4	29.0
Residents aged 65 and over:				
Total	235,686	464,213	616,883	1,316,782
Dementia	41,410	57,390	74,841	173,641
Percent	17.6	12.4	12.1	13.2
Other mental illness	6,358	20,886	23,136	50,560
Percent	2.8	4.5	3.8	3.8
All mentally ill	47,948	78,276	97,977	224,201
Percent	20.3	16.9	15.9	17.0

Note: Classification of residents is based on all sources of payment, regardless of dollar amount. Residents may (and often do) have more than a single source of payment. A few residents were reported as having been paid as both Medicaid SNF and Medicaid ICF residents; these were recorded in the Medicaid SNF column. Residents classed as "Other" relied solely on sources other than Medicaid.

All residents with a primary diagnosis in ICD-9 codes 290 through 317 are included in this table. Those with ICD-9 codes 290-294 (inclusive) and 310.9 were classed as having dementia.

Source: All figures are estimates prepared by the Congressional Research Service, Education and Public Welfare Division. All estimates are based on data contained in the 1985 National Nursing Home Survey.

1. CLASSIFICATION OF IMDS

In guidelines issued in 1982, HCFA put forth a number of criteria for classifying a facility as an IMD, including: whether the facility was licensed for or specialized in psychiatric care, the proportion of the facility's patients who were mentally ill or who had come to the facility directly from State mental institutions, and the average age of the patients (a young population was taken to indicate that the facility was treating mental rather than physical problems). Beginning in 1982, HCFA determined that some ICFs in a number of States were IMDs. Resulting disallowances of Federal funding were appealed by several of the States.

In general, the most important issue in the appeals has been the extent to which HCFA could properly classify a facility as an IMD on the basis of patient diagnosis alone, as opposed to the nature of the services provided.[11] The results, in a series of Federal cases, have been inconclusive, partly because several of the cases involved facilities that were clearly specializing in the treatment of mental disorders.[12]

In revised guidelines issued in 1986, HCFA continued to take the position that a preponderance of patients with a diagnosis of mental illness may be an important criterion, if not the only criterion, in determining whether a facility is an IMD. Moreover, the guidelines indicate that patients with both physical and mental problems may be considered as mentally ill if the mental problem alone would require institutionalization, even in the absence of the physical problem. This means that patients who entered the home for some other reason and who suffered mental deterioration could be considered as mentally ill for the purpose of an IMD determination.

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[11] The one case that reached the Supreme Court turned on another issue, whether HCFA could ever, on any basis, determine that an ICF was an IMD. The Court held that it could. *Connecticut Department of Income Maintenance* v. *Heckler*, 105 S.Ct. 2210 (1985).

[12] See Intergovernmental Health Policy Project, p. 6-9, for a review of this litigation.

Under this approach, a substantial number of SNFs and ICFs with an aged population could potentially be considered as IMDs. While this would not necessarily affect reimbursement for patients over age 65, who are eligible for IMD services, Federal funds could be denied for any younger Medicaid patients in the same facilities. In addition, funds could conceivably be denied retroactively for all patients in such facilities in the States which have never formally exercised the option of covering IMD services at the SNF or ICF level. As of October 1987, 29 States included these services in their State Medicaid plan. Another 15 covered IMD services, but only at the inpatient hospital level of care.

2. ACTIVE TREATMENT REQUIREMENTS

The States' potential defense in the IMD dispute—that the patients in ordinary nursing facilities are not receiving the type of care characteristic of IMDs—has given rise to an opposite concern: that some of the mentally ill patients may not be receiving active mental health treatment and may be inappropriately placed. Similar concerns have been raised about the mentally retarded. A 1987 General Accounting Office study of mentally retarded patients in nursing homes in three States found that many patients were receiving no treatment and that their ability to benefit from treatment had not been assessed.[13]

Concern about the treatment of both the mentally ill and the mentally retarded is reflected in the nursing home reform measures included in the Omnibus Budget Reconciliation Act of 1987 (OBRA87, Public Law 100-203). States will now be required to have screening and evaluation programs for the mentally ill (as well as for the mentally retarded) in nursing homes, as follows:

- By January 1, 1989, each State must have in effect a preadmission screening program to determine whether the placement of any new mentally ill or mentally retarded patient in a SNF or ICF is appropriate, or whether the patient would be more appropriately cared for in some other setting. Federal funds will be denied for placements found to be inappropriate;
- By April 1, 1990, each State must complete a review of all current mentally ill or mentally retarded ICF or SNF patients to determine whether continued care at the current level is appropriate. For those inappropriately placed, the State must arrange for safe and orderly discharge and active treatment.

Under the law, an individual is considered mentally ill if he or she has a primary or secondary diagnosis of mental disorder and does not have a primary diagnosis of Alzheimer's disease or other forms of dementia. As was noted above, an estimated 77 percent of mentally ill nursing home residents aged 65 and over, and an unknown proportion of younger mentally ill residents, have a primary diagnosis of dementia and will therefore not be subject to review. On the other hand, many residents whose primary problems are physical may still have a secondary diagnosis of mental disorder (such as senility or memory loss) and would be reviewed.

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[13] U.S. Congress. General Accounting Office. Medicaid: Addressing the Needs of Mentally Retarded Nursing Home Residents. Report to the Secretary of Health and Human Services. Washington. April 1987. [GAO/HRD-87-77]

Some State officials have expressed concern that, once the new rules go into effect, they will be obliged to transfer many patients from nursing facilities to other facilities or programs for which Medicaid funds will not be available.[14]

III. ACUTE CARE SERVICES

Medicaid programs also furnish mental health care as part of the general coverage of services rendered by physicians, clinics, hospitals, and other providers. The distinctions noted earlier, between mental health providers, mental health services, and ordinary services for a diagnosis of mental illness, have affected Medicaid policies relating to short-term, as well as long-term, care.

As was discussed in chapter III, there is a general requirement that States may not vary the amount, duration, or scope of Medicaid services on the basis of diagnosis. This has meant that a Medicaid program could not, for example, limit stays in acute general hospitals for patients with a psychiatric diagnosis, unless similar limits were applied to stays for all diagnoses.

States may, however, define distinct types of providers that furnish only mental health care services. These could include specialized mental health care clinics or such providers as clinical psychologists or psychiatric social workers. Coverage of these provider types may then be subject to special coverage limits, or the State may decline to cover any services rendered by these types of providers.

Some States have also defined distinct mental health services delivered by broader classes of providers. The State may, for example, distinguish between an ordinary physician office visit and a "psychotherapy visit," and limit coverage of the latter. A 1984 survey found that 17 States had imposed some limits on mental health services by physicians, outpatient hospital clinics, or both.[15] Limits ranged from requirements that preauthorization be obtained before furnishing certain psychiatric services to absolute restrictions on the number of visits or the dollar amounts that would be reimbursed in a given time period.

A. PHYSICIAN AND OTHER PRACTITIONER SERVICES

In most States, Medicaid beneficiaries may obtain services from psychiatrists under the same rules that apply when they obtain services from physicians in other specialties. Beneficiaries may also receive some mental health care from physicians who are not psychiatrists.

Psychiatrists have been less willing than any other group of physicians to accept Medicaid patients. As Table G-1 in Appendix G indicates, only 57.8 percent of psychiatrists participated in the Medicaid program in 1977-78, compared to 77.5 percent of primary care physicians, 73.4 percent of medical specialists, and 82.9 percent of surgical specialists.

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[14] U.S. Congress. House. Committee on Government Operations. From Back Wards to Back Streets: The Failure of the Federal Government in Providing Services for the Mentally Ill. [House Rep. 100-541] Washington. 1988. p. 11.

[15] Intergovernmental Health Policy Project, p. v.

Even more than other kinds of physicians, psychiatrists may be deterred from participating by States' reimbursement and coverage policies. Some States that have not imposed the specific limits on psychotherapy services cited above may have general limits on the number of physician office visits a beneficiary may receive during a given period (see chapter III for a discussion of these limits). Others may pay a flat rate for a physician visit, regardless of its duration. Either of these policies could have a disproportionate impact on the services of psychiatrists, who may tend to provide longer courses of treatment or longer individual visits than other physicians.

Only a minority of States cover the services of other types of mental health professionals. Clinical psychologists were covered in 21 States in 1984, but only three covered any other type of professional, such as clinical social workers or psychiatric nurses. The coverage rules depend in part on which types of professionals are permitted to practice independently under State law. Other States may pay for services furnished by psychologists or other mental health professionals if they are providing services under the direct supervision of a physician, either in the physician's office or in a clinic setting.

B. Mental Health Clinics and Other Outpatient Services

Services in mental health clinics were covered by 44 States as of 1984. The clinic providers may include State or county facilities, often funded through the Federal mental health services block grant, as well as private providers.[16] Direct patient services in mental health clinics are generally provided by nonphysician mental health professionals, such as psychologists or social workers. In many States a physician is expected to oversee the activities of the direct providers, developing a treatment plan or periodically reviewing the care being furnished.

States also cover mental health services furnished in hospital outpatient departments. In a number of States, outpatient mental health services may include "partial hospitalization" or "psychiatric day care" programs. These provide services in a structured setting for part of the day for patients living in the community. Some States cover comparable programs furnished by mental health clinics.

Despite the limitations on Medicaid coverage of outpatient mental health care services, it has been found that Medicaid beneficiaries are more likely to obtain mental health care than other low-income persons without Medicaid or even than higher-income persons.[17] Table E–4 shows the probability of obtaining any health care, and any mental health care, during a year for three groups:

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[16] OBRA 1987 provided that States could cover, as clinic services, services provided by clinic personnel outside the actual clinic facility. This provision permits clinics to furnish offsite care to homeless chronically mentally ill patients in shelters or other locations.

[17] Taube, Carl A., and Agnes Rupp. The Effect of Medicaid on Access to Ambulatory Mental Health Care for the Poor and Near-poor under 65. Medical Care 24:8 (Aug. 1986), p. 677–86.

low-income persons with and without Medicaid and higher-income persons.

Table E–4.—PROBABILITY OF USE OF AMBULATORY HEALTH AND MENTAL HEALTH SERVICES, PERSONS UNDER 65 BY POVERTY STATUS AND MEDICAID COVERAGE, 1980

Poverty and Medicaid Status	Probability of Ambulatory Health Use	Probability of Ambulatory Mental Health Use
Total	.776	.045
Poor or near-poor:		
Medicaid enrolled all year	.779	.079
Non-Medicaid	.716	.046
Non-poor, non-Medicaid	.791	.038

Source: Taube, Carl A., and Agnes Rupp. The Effect of Medicaid on Access to Ambulatory Mental Health Care for the Poor and Near-Poor under 65. Medical Care. vol. 24, no. 8. p. 677 86. Aug. 1986.

The three groups were about equally likely to have received some health care services during the year. However, Medicaid beneficiaries were nearly twice as likely to have received mental health care during the year than persons classified as "non-poor," and about 70 percent more likely than other poor or near-poor persons. The authors speculate that the non-poor were deterred from obtaining mental health services because private health insurance may limit or exclude coverage of these services.

Another study, by Shapiro et al., attempted to measure the relative need for mental health care of the poor and near-poor, with and without Medicaid coverage, and the non-poor (table E–5). Medicaid beneficiaries who also received public assistance were nearly three times as likely as the non-poor to need mental health services, while beneficiaries who did not receive public assistance were more than twice as likely as the non-poor to need mental health care. (The measurement of need considered both actual use of mental health services and manifestations of emotional problems not accompanied by use of such services.) The study also found, however, that Medicaid beneficiaries were somewhat more likely to have their needs met. This was especially true of those receiving public assistance; 38.3 percent were found to have unmet need, compared to 47.4 percent of the non-poor.

Table E–5.—NEED FOR MENTAL HEALTH CARE AND UNMET NEED BY POVERTY STATUS

	Percentage with Need for Care	Percentage of those who Need Care, but Need Is Unmet
All persons	13.6	47.4
Medicaid:		
With public assistance	33.8	38.3
Without public assistance	23.8	46.8
Poor and near poor without Medicaid [1]	13.1	55.6
Non-poor	11.4	47.4

[1] Includes persons with income not more than 150 percent of poverty.

Source: Shapiro, Sam, et al. Measuring Need for Mental Health Services in a General Population. Medical care. vol. 23, no. 9. p. 1039. Sept. 1985.

C. Hospital Inpatient Services

Short-term acute care for mental illness is an important component of Medicaid inpatient hospital expenditures in some States. These services may be provided in a general hospital, whether or not the hospital has distinct psychiatric wards or units. Under Medicaid rules, however, even short-term services in a facility or part of a facility specifically licensed as a psychiatric hospital would not constitute ordinary hospital care and would be subject to the coverage limitations for IMD or psychiatric hospital services.

Table E–6 shows the results of a detailed HCFA analysis of 1982 Medicaid payment records from three States, California, Michigan, and New York. Within the three State sample, there is considerable variation in the proportion of expenditures and utilization devoted to care of psychiatric diagnoses. Mental disorders account for just 3 percent of hospital costs in California, but nearly 20 percent in New York. In the absence of detailed data from other States, there is no way of knowing whether New York or California is more nearly representative of the national experience.[18]

Table E–6.—MEDICAID INPATIENT SERVICES FOR MENTAL DISORDERS AND FOR ALL DIAGNOSES, CALIFORNIA, NEW YORK AND MICHIGAN, 1982

	California	Michigan	New York
Total discharges	628,455	199,070	493,340
Discharges for mental disorders	18,511	10,509	42,908
Percent, mental disorders	2.95	5.28	8.70
Total days (est.)	3,959,267	1,413,397	3,897,386
Days for mental disorders (est.)	207,323	171,296	862,450
Percent, mental disorders	5.24	12.12	22.13
Total payments (thousands of dollars):			
All diagnoses	$1,547,964	$350,830	$1,206,876
Mental disorders	47,521	30,845	236,647
Percent, mental disorders	3.07	8.79	19.61
Average payment per day (est.):			
All diagnoses	$390.97	$248.22	$309.66
Mental disorders	229.21	180.07	274.39

Note: Days and per diem payments estimated, using published data on discharges, total payments, and average length of stay. Data include stays in inpatient psychiatric hospitals.

Source: Pine, Penelope, Embry M. Howell, and William Buczko. Hospital utilization and expenditures for Medicaid enrollees by major diagnosis group. Health Care Financing Review. vol. 9, no. 1. p. 91 96. Fall 1987.

Two patterns hold across all three States. First, each day of care for a person with a diagnosis of mental disorder is less expensive than a day of care for other diagnoses. This is presumably because psychiatric patients receive fewer of the ancillary services, such as diagnostic tests, that increase the charges for other kinds of patients. Second, patients with a diagnosis of mental disorder stay in the hospital significantly longer than other kinds of patients.

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[18] It should be noted that the data include discharges from inpatient psychiatric hospitals for beneficiaries under age 22. As the national total of beneficiaries receiving these services in fiscal year 1982 was only 23,362, the impact on the discharge totals reported here is likely to be minimal. Data on IMD services are not included. The data are drawn from the Medicaid "tape-to-tape" project, in which 5 States have furnished complete computer data on all Medicaid transactions to HCFA for statistical analysis (the researchers were unable to use data from 2 of the 5 States). Other States provide only summary statistical reports, such as the HCFA-2082 reports from which many of the statistics in this report are drawn.

However, several studies have found that Medicaid beneficiaries treated for mental disorders have shorter hospital stays than comparable patients covered by other insurers. Frank and Lave found that Medicaid stays were especially short in States that had general limits on the number of inpatient days covered, per admission or per year. Coverage limits also had some impact on the chances of a patient's being discharged to another facility, rather than to the community.[19]

A recent analysis of 1970–1977 data by Jacqueline Wallen found that differences between Medicaid and private patients, both in length of stay and in likelihood of discharge to another facility, remained even after correction for the severity of the patients' problems at the time of admission.[20] Wallen suggests that the higher number of discharges to other facilities could indicate that the outreach and treatment services that would permit discharge to the community are harder to arrange for Medicaid beneficiaries.

IV. STRUCTURED CARE SYSTEMS FOR MENTAL ILLNESS

A number of observers have suggested that Medicaid policies have resulted in discontinuous and uncoordinated care for the mentally ill.[21] Coverage limits may result in some beneficiaries being shifted from one treatment setting to another—from outpatient services to an inpatient hospital, from a general hospital to a State institution, from the State facility to a nursing home or back to the community. States have experimented with a variety of systems meant to improve the management of Medicaid mental health services.

A. Case Management Programs

Three States, Michigan, Utah, and Wisconsin, have used the section 2175 waiver authority established by the Omnibus Budget Reconciliation Act of 1981 (OBRA81, Public Law 97–35) to develop programs to serve the mentally ill. (None of the three programs was still in operation as of January 1988.) Section 2175, as described in chapter V, permits a State to obtain waivers of the Medicaid "freedom of choice" requirement and other rules in order to require selected groups of beneficiaries to participate in a primary care case management system, under which all of a patient's treatment must be provided or authorized by a single physician or other primary care provider. These programs are designed to reduce unnecessary duplication of services and provide care more efficiently.

B. Home and Community-Based Services Waivers

States have used the OBRA81 section 2176 waiver authority to develop home and community-based services programs for the chronically mentally ill who would otherwise qualify for institutional services under Medicaid. Section 2176 waivers, also described in chapter V, allow a State to develop a coordinated care system for a target population and to provide medical and social services to this population that are not available to other Medicaid beneficiaries. Only one State, Vermont, currently operates a program specifically targeted at the chronically mentally ill. Other States may serve the mentally ill under programs serving a broader group of disabled beneficiaries.

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[19] Frank, Richard, and Judith Lave. The Impact of Medicaid Benefit Design on Length of Hospital Stay and Patient Transfers. Hospital and Community Psychiatry, 36:7 (July 1985), 749-753.

[20] Wallen, Jacqueline. Case Mix and Treatment Patterns of Medicaid and Privately Insured Psychiatric Patients in Short-term General Hospitals. Hospital Cost and Utilization Project Research Note 9, DHHS Publication No. (PHS) 87-3402. 1986.

[21] See House Committee on Government Operations, 1988, for a summary of some of the problems reported by mental health specialists.

C. Targeted Case Management

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, Public Law 99–272) authorized States, without a waiver, to provide case management services to target groups of Medicaid beneficiaries. These optional services, which do not involve any restriction on beneficiaries' freedom of choice, are intended to improve access to and coordination of the Medicaid services required by a special population, such as the disabled, pregnant women, or young children. As of August 1987, four States had implemented targeted case management programs for the chronically mentally ill and the developmentally disabled: California, Colorado, Minnesota, and North Carolina. One other State, Wisconsin, included the chronically mentally ill among a wide variety of populations for whom case management would be made available.[22]

D. Program for the Chronically Mentally Ill

Finally, OBRA87 authorized special waivers of Medicaid rules to facilitate a set of demonstration projects being conducted by State and local governments under a Program for the Chronically Mentally Ill, cosponsored by the Robert Wood Johnson Foundation and the U.S. Department of Housing and Urban Development. Approved projects will be able to receive per capita payment for all Medicaid services required by their clients, much as if they were HMOs. This funding mechanism might allow the projects to improve the management and coordination of the services their clients receive; any savings from reduced use of hospital care or other expensive services would help to finance additional services for the clients, such as residential treatment, psychosocial rehabilitation, and case management. Waivers would be for an initial period of 3 years, with a possible 2 year renewal. The Secretary's authority to grant the waivers expires in October 1991; a report to Congress on the demonstration projects is due no later than January 1, 1993.

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[22] Intergovernmental Health Policy Project. Major Changes in State Medicaid and Indigent Care Programs: January–August 1987. Washington. 1987.

APPENDIX F. MANAGED CARE [1]

I. INTRODUCTION

In recent years, States have experimented with managed care programs to reduce unnecessary utilization of Medicaid services and possibly achieve greater coordination and continuity of care. The phrase "managed care" is used in a variety of senses; for the purpose of the following discussion, the term is used to refer to systems in which the overall care of a patient is overseen by a single provider or organization.

The basic model for managed care is the health maintenance organization, or HMO, which receives a fixed periodic payment (known as a capitation payment or premium) for each individual served and accepts financial responsibility for all the medical care required by that individual. If the beneficiaries enrolled under the arrangement use more, or more costly, services than anticipated, the HMO may suffer a loss. If the enrollees use fewer services than anticipated, the HMO may realize a profit. The organization is therefore said to be "at risk" for the set of services covered by the contract. The risk arrangement is intended to give the HMO a financial incentive to furnish services more efficiently.

Persons enrolled in the HMO receive all services, except in emergencies, from providers employed by or affiliated with the HMO. Ordinarily, the enrollee has a single primary care physician, who must authorize specialty care and inpatient hospital services. The HMO may pass on to physicians some of its own financial incentives to reduce unnecessary services. In some arrangements the physicians receive a fixed monthly payment for their assigned patients or are partially at risk for the costs of services they order; in others, the physicians may share in profits or losses at the end of a year. Their medical decisions may also be subject to review by the central HMO administration. In addition to reducing the use of services, HMOs may also achieve savings by contracting with low-cost hospitals and other providers, or by negotiating discounts from providers' usual charges.[2]

The managed care concept has been of interest to Medicaid programs, as well as to other purchasers of health care, because it appears to offer a way of changing provider and beneficiary behaviors which may have contributed to rising costs in the traditional fee-for-service system. In at least some areas, many Medicaid beneficiaries receive routine health services in hospital outpatient departments and emergency rooms, at greater cost than if they had used office-based physician services. In other areas, some beneficiaries engage in "doctor shopping," visiting multiple providers for a single complaint. The providers themselves, paid for each service they perform, may have an incentive to maximize their own services and may have no reason to control the referral services they order. Managed care, it is argued, can provide control over the beneficiaries' behavior and change the incentives for providers.

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[1] This chapter was written by Mark Merlis.

[2] Some analysts believe that HMOs can also achieve savings through preventive medicine—finding problems early, before they become more serious and expensive to treat. Others believe that these "health maintenance" practices are not a significant factor in HMO savings.

Critics of managed care programs say that providers may respond to the new incentives, not just by providing care more efficiently, but also by denying needed services. Reports of quality problems and other abuses in some Medicaid managed care experiments have led Congress to place restrictions on the types of organizations that may participate and on the terms under which the programs may operate. Still, 30 States were operating some form of managed care program by the end of 1987.

Many States have contracted with HMOs to furnish services to beneficiaries. Others have developed systems that retain some of the managed care features of HMOs but that do not involve the substantial risks (and hence the need for capital and experienced management) presented by HMOs. Some States have used fee-for-service case management. Individual physicians or groups are paid a fee to manage the care of assigned patients but are not at direct financial risk for the services the patients use. Other States have developed "partial capitation systems." The providers are paid a premium for each enrollee and accept financial risk for a limited group of services, such as all physician and diagnostic services, but are not at risk for the most expensive services, such as hospital inpatient. Finally, some States have experimented with health insuring organizations, or HIOs, which are a cross between HMOs and fee-for-service case management programs.

This appendix reviews States' experiences with each of these types of managed care systems and discusses their current status and possible future role in the Medicaid program.

II. HISTORY OF MANAGED CARE UNDER MEDICAID

A. HMO Contracting Before 1981

Some States began contracting with HMOs or similar entities almost immediately after implementing their Medicaid programs.[3] The earliest initiatives were in the States where HMOs were already a relatively familiar concept. In New York City, for example, where municipal employees had long been enrolled in the HMO-like Health Insurance Plan of Greater New York (HIP), membership in HIP was made available to Medicaid beneficiaries as early as 1967. The State of Washington began contracting with Group Health of Puget Sound in 1970, while the various regional operations of Kaiser-Permanente were accepting Medicaid enrollments in three different States by 1972.

The earliest significant commitment to Medicaid prepaid contracting came in California, where concerns about the escalating costs of the Medicaid program had led to stringent cost containment measures, including tight restrictions on physician services, by the early 1970's. Prepaid health plans were promoted as an alternative way of achieving savings. The State entered into numerous prepaid contracts, both with established HMOs and brand-new ones—many of them formed solely to deal with Medicaid. The contractors marketed directly, "door to door," to beneficiaries, and enrollment grew rapidly.

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[3] As chapter V indicates, States may enter into risk contracts with a variety of organizations that are not technically HMOs and that are known as prepaid health plans or PHPs. In the following discussion, the term HMO will generally be used to include both HMOs and PHPs.

Soon, however, there were reports of abuses in the California prepaid program. Some of the contractors used unscrupulous marketing approaches, telling beneficiaries that the State required them to join an HMO, failing to disclose that HMO members had to use the HMOs own providers, or offering additional benefits which never materialized. Some contractors were reported to have engaged in "skimming," refusing to enroll potentially high-cost beneficiaries. Once beneficiaries had joined an HMO, they had trouble getting out; contractors would delay disenrollment requests or refuse to accept them at all. There were quality of care problems as well: some of the organizations were unable to, or refused to, furnish the full scope of Medicaid benefits. Others were financially unsound, leaving beneficiaries at risk of becoming liable for their own medical bills. Still others were reported to have diverted funds from medical services through contracts with profitmaking affiliates.[4]

California responded to these problems by enacting more rigorous requirements for HMOs. Federal demonstration funds were made available to develop a model Medicaid HMO contracting and monitoring system. However, national reports of the abuses in California and of similar problems in some of the other States experimenting with prepayment led to congressional action as well.

The Health Maintenance Organization Amendments of 1976 (Public Law 94–460) included the first specific Federal requirements for Medicaid contracts with HMOs or comparable organizations. Full-service risk contracts could be offered only to Federally qualified HMOs, those certified by the Secretary as meeting organizational, financial, and quality standards set forth in Title XIII of the Public Health Service Act. Exceptions were made for certain Federally funded community or migrant health centers and for organizations, such as HIP of New York, which had Medicaid contracts prior to 1970. In addition, an HMO which had applied for Federal qualification but which had not yet received a final determination could be deemed "provisionally qualified" by the State, and could continue to contract with Medicaid on that basis until the application was approved or denied.

The Act also forestalled further development of Medicaid-only HMOs through a provision that no more than 50 percent of a risk contractor's enrollees could be Medicaid or Medicare beneficiaries.

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[4] The problems in the California program are detailed in three General Accounting Office reports. Better Controls Needed for Health Maintenance Organizations under Medicaid in California. Report to the Committee on Finance, United States Senate. Sept. 1974. [B-164031(3)] Deficiencies in Determining Payments to Prepaid Health Plans under California's Medicaid Program. Report to the Committee on Finance, United States Senate. Aug. 1975. [MWD-76-15] Relationships between Nonprofit Prepaid Health Plans with California Medicaid Contracts and For Profit Entities Affiliated with Them. Nov. 1976. [HRD-77-4]

Again, exceptions were made for Federally funded centers and pre-1970 contractors. New contractors could take up to 3 years to meet the requirement if they could show that they were making satisfactory progress towards compliance.

The effect of these changes was generally to limit new State prepaid initiatives to established organizations which could complete the protracted and elaborate Federal qualification process, as well as to eliminate some existing contractors unable to meet the Federal standards. Although some States, faced with the rapid increases in Medicaid costs of the late 1970's and early 1980's, were interested in trying prepaid approaches, they found that established HMOs were reluctant to take on a Medicaid contract. A number of factors deterred HMOs from participating: [5]

- There was a widespread perception in the HMO industry that Medicaid beneficiaries were costly and had difficulty adjusting to an HMO environment, tending to continue using emergency rooms and other nonplan providers. Some HMOs regarded Medicaid reimbursement rates as inadequate.
- In the private sector, HMOs were accustomed to marketing to large employer groups through direct presentations, mailings, or other means during periodic open seasons. Medicaid beneficiaries were less accessible; they were never assembled in a single place, as employees are at the worksite, and Federal confidentiality rules prohibited the release of their names to HMOs. Medicaid marketing was a costly, hit-or-miss process, often requiring door-to-door canvassing.
- Beneficiaries often had little incentive to enroll. In the private sector, HMOs competed by offering lower out-of-pocket costs or more benefits than other health plans. Medicaid beneficiaries had virtually no out-of-pocket costs, and some States' Medicaid benefits were so comprehensive that HMOs were unable to develop appealing add-ons.
- While private enrollees generally remained enrolled for a year, between annual open enrollment periods, Medicaid beneficiaries might be enrolled for much briefer periods, either because they withdrew voluntarily or because they became ineligible for Medicaid benefits.
- Some HMOs were concerned that participation in Medicaid would give them a "welfare image," hindering them in private market competition.
- HMOs in some States found Medicaid reimbursement rates unacceptable. Federal regulations require that premiums paid for Medicaid beneficiaries enrolled in an HMO not exceed the average amount that would have been paid for the same group of beneficiaries if they had been treated outside the HMO. Medicaid HMO premiums therefore reflected the discounted prices paid by Medicaid in the fee-for-service sector, although HMOs might have been unable to obtain comparable discounts from hospitals or other providers.

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[5] For a summary of the status of Medicaid HMO contracting as of early 1981 and the outstanding problems at that time, see Trieger, Sidney, Trudi W. Galblum, and Gerald Riley. HMOs: Issues and alternatives for Medicare and Medicaid. Baltimore. 1981. [HCFA Pub. No. 03107]

As a result of these barriers, along with the reluctance of many States to experiment with the HMO approach, only 281,926 beneficiaries were enrolled in HMOs in June 1981, little more than 1 percent of the Medicaid population. Of the HMO enrollees, 85 percent were in just four States: California, Maryland, Michigan, and New York.

B. Legislative Changes, 1981–82

The Omnibus Budget Reconciliation Act of 1981 (OBRA81, Public Law 97–35) gave States greater flexibility in contracting with HMOs and also allowed States to explore other managed care approaches.

There were four important changes in the Federal Medicaid HMO contracting rules. First, Medicaid contracts were no longer limited to Federally qualified HMOs. The State could make its own determination that an organization was qualified, if the HMO demonstrated its capacity to provide covered services and to protect beneficiaries from liability in the event of the organization's insolvency. Second, up to 75 percent of an organization's enrollees could be Medicaid and Medicare beneficiaries, as opposed to the previous 50 percent limit. Third, States could offer "guaranteed eligibility" to beneficiaries joining Federally qualified HMOs. The State could continue paying premiums on an enrollee's behalf for up to 6 months following the date of initial enrollment, even if the enrollee ceased to be eligible for Medicaid benefits during that period. While these three changes expanded States' options, a fourth limited them: States could not restrict voluntary disenrollment. Beneficiaries had to be permitted to terminate their enrollment in an HMO at any time, with the termination taking effect no later than the end of the month following the month in which the beneficiary requested disenrollment.

OBRA81 also established the section 2175 freedom-of-choice waiver program, under which States could require beneficiaries to enroll in some form of managed care system. (Details of the section 2175 provisions may be found in Chapter V.)

As enacted, section 2175 permitted the Secretary to waive provisions of two parts of the Medicaid law: section 1902 (which included such basic requirements as freedom of choice, uniform statewide operation, and comparability of benefits for different types of beneficiaries), and section 1903(m), the section of the Medicaid law that contained the basic rules for prepaid contracts. Several States applied for and obtained waivers of section 1903(m) provisions, allowing them to contract with organizations which did not meet contract eligibility requirements (such as the 75 percent Medicaid/Medicare enrollment limit) or to restrict enrollees' ability to disenroll without cause.

These waivers, in combination with waivers for a primary care case management program, might have permitted a State to require all Medicaid beneficiaries to enroll in a single HMO serving Medicaid patients only. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA, Public Law 97–248) repealed the Secretary's authority to waive requirements in connection with a section 2175 waiver program; waivers already granted could continue but could not be renewed after their original 2-year term. The Secretary retained the authority to waive HMO requirements in order to conduct short-term demonstration projects.

C. Recent Developments

The TEFRA change in the Secretary's waiver authority left States with four major managed care options:

1. Promotion of voluntary enrollment in HMOs;
2. Voluntary or mandatory enrollment in fee-for-service or "partial capitation" primary care case management systems;
3. Voluntary or mandatory enrollment in "health insuring organizations," which resembled HMOs, but were not at first subject to 1903(m) requirements, for reasons to be detailed below;
4. Mandatory enrollment in multiple-HMO systems, under which a beneficiary could voluntarily disenroll from one organization but would then be required to join another;

The following section provides an overview of the ways in which States have made use of these basic options. Table F-1 summarizes the programs in operation in 1986; table F-2 gives State-by-State details of fee for service case management programs as of mid-1986. Table F-3 gives similar data for capitated programs as of December 1987. The section concludes with a brief discussion of the "social health maintenance organization" (S/HMO) demonstrations and similar experiments. These programs, targeted at the elderly, are largely a Medicare initiative but have some Medicaid involvement.

Table F-1.—TYPES OF MEDICAID MANAGED CARE PROJECTS AND ESTIMATED ENROLLMENT, 1986

	Number of States	Enrollees, mid-1986	Enrollees, Dec. 1987
Health Maintenance Organizations (HMOs) and Full Risk Prepaid Health Plans (PHPs):			
Voluntary enrollment	22		660,657
Mandatory enrollment	5		294,961
Partial Capitation Plans:			
Voluntary enrollment	4		24,062
Mandatory enrollment	1		31,657
Health Insuring Organizations (HIOs), managed care type:			
Voluntary enrollment	1		10,460
Mandatory enrollment	3		120,225
Social HMOs (including On Lok)	4		497
Fee-for-service Case Management:			
Voluntary enrollment	3	11,560	
Mandatory enrollment	7	397,250	
Total	50	408,810	1,142,519

Source: U.S. Library of Congress. Congressional Research Service analysis of HCFA data. Case management program data are unpublished estimates by the National Governors' Association.

Table F–2.—FEE-FOR-SERVICE CASE MANAGEMENT PROJECTS BY STATE, 1986

State	Voluntary or Mandatory	Population Served	Enrollees 6/86
California	Voluntary	AFDC–SSI	3,560
Colorado	Mandatory, Statewide	AFDC (except foster care)	[1] 67,250
Connecticut	Mandatory, Middlesex	Most AFDC, blind, disabled	1,100
Kansas	Mandatory, 4 urban areas	All	41,700
Kentucky	Mandatory, 109 of 120 counties	Most AFDC, AFDC-related	185,000
Michigan	Mandatory,Wayne	Most categorically needy (optional for medically needy).	[1] 82,300
New Jersey	Voluntary	AFDC	5,000
Tennessee	Mandatory, Maury	All except Medicare/Medicaid elig	1,700
	Voluntary	AFDC and medically needy under 21	ca. 3,000
Utah	Mandatory, Wasatch Front	All categorically eligible	[1] 18,200

[1] Fee-for-service case management only. Mandated enrollees choosing prepaid program included in HMO count.

Source: Congressional Research Service analysis of HCFA data. Mid-1986 case management estimates obtained from the National Governors' Association.

Table F–3.—MEDICAID CAPITATION PROGRAMS BY STATE, 1987

State	Program type (number of providers in parentheses)	Voluntary or mandatory	Population served	Prepaid Enrollees 12/87
Alabama	HMO (1)	Voluntary	AFDC–SSI	1,742
Arizona	PHPs (14)	Mandatory, Statewide	AFDC–SSI	130,224
California	HMOs, PHPs (14)	Voluntary	All	262,366
	Partial capitation (15)	Voluntary	All	12,614
	On Lok program	Voluntary	Aged	252
	HIO, managed	Mandatory, Santa Barbara	All	21,912
Colorado	HMOs (4)	Voluntary	All	7,249
Connecticut	HMO (1)	Voluntary	AFDC	458
District of Columbia	HMO (1)	Voluntary	All	61
Florida	HMOs (7)	Voluntary	AFDC (3), AFDC–SSI (4)	29,577
Hawaii	HMO (1)	Voluntary	AFDC	2,613
Illinois	HMOs (8)	Voluntary	AFDC	115,205
Indiana	HMO (1)	Voluntary	AFDC	1,541
Iowa	HMO (3)	Voluntary	AFDC (1), AFDC–Foster (2)	1,308
Maryland	HMOs, PHPs (4)	Voluntary	All	[1] 31,134
Massachusetts	HMOs (13)	Voluntary	All (4), AFDC (6), Not reported (3).	12,071
Michigan	HMOs (7)	Voluntary	AFDC–SSI	90,679
	Partial capitation	Voluntary	All	[2] 4,300
Minnesota	HMOs/PHPs (10)	Mandatory/Voluntary [3]	AFDC–SSI (7), AFDC (3)	24,040
	Social HMO (1)	Voluntary	Aged	28
Missouri	HMOs (4)	Mandatory, Jackson	AFDC	18,147
New Hampshire	HMO (1)	Voluntary	AFDC	762
New Jersey	HMOs (2)	Voluntary	AFDC	1,005
New York	HMOs, PHPs (4)	Voluntary	AFDC–SSI (2), AFDC (3)	16,511
	HMO (1)	Mandatory, Monroe	AFDC	8,242
	Social HMO (1)	Voluntary	Aged	122
	Partial capitation (1)	Voluntary	All except AFDC	5,652
North Carolina	HMO (1)	Voluntary	AFDC	3,098
	Partial capitation (1)	Voluntary	AFDC	1,496
Ohio	HMOs (17)	Voluntary	AFDC	42,418
Oregon	Partial capitation (15)	Mandatory: Multnomah, Clackamas, Polk, Marion, Washington.	AFDC	31,657
	Social HMO (1)	Voluntary	Aged	95
Pennsylvania	HMOs, PHPs (4)	Voluntary	All (2), AFDC (2)	[1] 19,604
	HIO, managed	Mandatory, S. Philadelphia	AFDC	91,092
Rhode Island	HMO (1)	Voluntary	AFDC	297

Table F-3.—MEDICAID CAPITATION PROGRAMS BY STATE, 1987—Continued

State	Program type (number of providers in parentheses)	Voluntary or mandatory	Population served	Prepaid Enrollees 12/87
Tennessee	HIO, managed	Voluntary	AFDC	10,460
Utah	HMO (2)	Voluntary	All	13,276
Washington	HMOs (3)	Voluntary	AFDC (2), AFDC–Foster (1)	7,678
	HIO, managed	Mandatory: Kitsap, Mason, Jefferson.	AFDC	7,221
Wisconsin	HMOs (12)	Mandatory: Milwaukee, Dane, Eau Claire.	AFDC	114,308

[1] Counts of enrollees may include beneficiaries covered by State-funded medical assistance program.

[2] Mid-1986 National Governors' Association estimate.

[3] As of Dec. 1987, Minnesota mandated HMO enrollment in Hennepin and Dakota counties and offered voluntary enrollment in other areas. Some HMOs operated in both the mandatory and voluntary areas.

Source: Congressional Research Service analysis of HCFA data.

1. VOLUNTARY HMO ENROLLMENT

As of December 1987, 660,657 beneficiaries were voluntarily enrolled in HMOs and other comprehensive prepaid health plans in 22 States. Although many mainstream HMOs still hesitate to consider a Medicaid contract, States have taken a number of steps to make Medicaid participation more attractive.[6]

In place of direct door-to-door marketing, which was costly and subject to abuse, several States have developed "dual choice" systems, in which beneficiaries are informed of their health care options at the time they apply for Medicaid benefits. Usually these systems involve State representatives, stationed in local social services offices, who describe the differences between the HMO and fee-for-service alternatives. In a few States the HMOs themselves have been given direct access to the social services offices.

Some States have implemented the guaranteed eligibility option described above, which prevents rapid involuntary disenrollment because of loss of eligibility and may promote continuity of care. As a result of a change in the Deficit Reduction Act of 1984 (Public Law 98–369), States are also permitted to restrict voluntary disenrollment without cause for up to 6 months (really 5 months following a 1 month trial period); the option applies to enrollees in Federally qualified HMOs and most types of prepaid health plans, but not to enrollees in State-qualified HMOs.

Despite these changes, voluntary HMO enrollment remains heavily concentrated in a few States. California, Illinois, Michigan, and Ohio accounted for 80 percent of the enrollment in December 1986; California and Michigan were also the major centers of HMO enrollment 5 years earlier.

A 1987 survey by the Group Health Association of America, an HMO industry organization, found that only 23 percent of the HMOs responding participated in the Medicaid program. In those that did participate, Medicaid beneficiaries constituted an average of 16.2 percent of the total enrollees. Participation was higher among new organizations, among those located in the East Central region, and among individual practice associations (those that used private office-based physicians to furnish services instead of using their own facilities and staff.) [7]

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[6] Neuschler, Edward. Alternative financing and delivery systems: Managed health care. In National Governors' Association, Center for Policy Research, Affording access to quality care: Strategies for State Medicaid cost containment. Washington. 1986. p. 201–245.

New Jersey has recently developed an alternative to State contracting with private HMOs. It has established its own organization, the Garden State Health Plan, to provide services to Medicaid beneficiaries. OBRA87 exempts this organization from some of the Medicaid HMO rules and allows New Jersey to offer guaranteed eligibility to enrollees in the plan.

2. PRIMARY CARE CASE MANAGEMENT

The reluctance of private market HMOs to serve a Medicaid clientele, along with the statutory constraints which inhibited the development of HMO-like programs for Medicaid beneficiaries alone, led States to look for other ways of obtaining the perceived advantages of HMO contracting—management of patients and financial incentives to improve efficiency. Operating under a section 1115(a) demonstration waiver, Massachusetts developed the first primary care case management program in 1979.

A beneficiary would select a single primary care provider and would agree to obtain covered services from other providers only with the primary care provider's authorization; the State would deny payment for any unauthorized services except emergency care. The primary care provider would manage the overall care of the patient and attempt to reduce unnecessary referral services or inpatient hospital admissions. The provider would serve as a "gatekeeper," an intermediary between the patient and the rest of the medical care system. Resulting savings could be shared with the State, perhaps in the form of an incentive payment for reduced hospitalization.

The Massachusetts program encountered startup problems, especially in the area of data processing, and did not produce clear results in the initial demonstration period. Nevertheless, the concept of primary care case management for Medicaid beneficiaries received considerable attention. As noted earlier, section 2175 of OBRA81 gave States the option of requiring beneficiaries to participate in a case management program.

Michigan was the first State to take advantage of the new option, obtaining approval for its Physician Primary Sponsor Plan in 1981. This program differed from the Massachusetts prototype in two major ways. First, while Massachusetts used a small number of community health centers or physician group practices as case managers, Michigan used individual physicians, each managing a limited number of cases. Second, enrollment in the Massachusetts program was voluntary; beneficiaries were offered cash incentives to participate.

Michigan, using the new freedom-of-choice waiver option, planned to require all AFDC beneficiaries in Wayne County (the Detroit area) to participate, or about 280,000 enrollees. However, the State encountered problems in matching so many beneficiaries with individual physicians. Many of the enrollees failed to select a physician on their own and were assigned to a provider by the State.[8] By mid-1986, 4 years after project implementation, only an estimated 82,000 beneficiaries had actually been enrolled.

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[7] Group Health Association of America. GHAA's 1987 Survey of HMO Industry Trends. Washington. 1987. p. 87–93. This survey was slightly skewed towards larger HMOs, and may not fully reflect overall industry participation in Medicaid.

In the years since the Michigan project began, two basic kinds of case management program have evolved. One model resembles Michigan's: the State contracts with individual physicians, paid on a fee-for-service basis, to oversee beneficiaries' care. The second model uses partial capitation: the primary care provider is paid a fixed premium, out of which it covers the costs of its own services and ambulatory referral care, such as specialty or diagnostic services. The State remains directly responsible for inpatient hospital care. This model was used extensively in Oregon, and has also been tried in parts of California and Michigan.

Most of the fee-for-service case management programs have involved mandatory enrollment. Usually only the AFDC-related beneficiaries are required to participate, in part because of problems of coordinating these systems with Medicare for the aged and disabled groups. Two case management programs, in Colorado and Kentucky, operated on a statewide basis in 1986; the rest are confined to individual counties or metropolitan areas. As Table F–1 indicates, the partial capitation programs have tended to rely on voluntary enrollment and have involved a relatively small number of participants.

3. THE HIO EXPERIMENTS

After TEFRA repealed the Secretary's authority to waive HMO rules for States wishing to include full capitation as part of a mandatory primary care case management program, some States began exploring approaches that might be permissible within the framework of existing law. One solution was the "health insuring organization," or HIO.

The first HIOs, operating in Texas and in limited areas of California from the 1970's, functioned basically as fiscal intermediaries, processing provider claims for the Medicaid agency. Unlike other fiscal intermediaries, however, an HIO was not simply a conduit for Medicaid funds. The State paid the HIO a fixed per capita amount for each beneficiary in the area the HIO served, and the HIO was expected to cover all Medicaid claims out of that single fixed amount. Within limits, the HIO could make a profit or suffer a loss. Unlike an HMO, the HIO did not manage the care of patients or require beneficiaries to use a limited group of affiliated providers. Instead, the HIO used cost control methods that, in other States, were practiced directly by the State agency, such as preauthorization of services or postpayment utilization review.

In the early 1980's, however, States cooperated with HCFA to find a way of incorporating managed care into the HIO structure. HCFA defined a new type of HIO, which could operate much like an HMO but which differed from HMOs in two respects:

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[8] Squarrell, Karen I., Suzanne M. Hansen, and Edward Neuschler. Prepaid and managed care under Medicaid: Characteristics of current initiatives. Washington. 1985. [National Governors' Association. Center for Policy Research.

- While an HMO could provide services directly, an HIO had to obtain all services through subcontractors, and no subcontractor could be at risk for both ambulatory and inpatient care.
- An HMO could select its own restricted set of participating providers. An HIO was required to accept any provider who could meet standard conditions of participation established by the HIO and who would agree to standard contractual terms.

HCFA determined that an organization meeting the HIO definition was not subject to the 1903(m) restrictions on prepaid contracts. This meant that an HIO could be exempted from the 75 percent Medicaid enrollment maximum and that the State could restrict disenrollment from an HIO. In effect, the entire Medicaid population could be required to enroll in a single entity, so long as beneficiaries remained free to select from among the providers participating in the HIO arrangement.

The first HIO program approved under the new rules was CitiCare in Louisville, Kentucky. All AFDC beneficiaries were enrolled under a single contract with CitiCare, which agreed to accept liability for the full scope of Medicaid services. Each beneficiary chose a primary care provider from among those participating in the program. The physician, group, or clinic selected was paid for its own services and shared in any savings resulting from reductions in referral and hospital inpatient care; some of these providers accepted full financial risk for referral services.

CitiCare lasted only a year, abandoned in a change of State administrations amid charges of inadequate access to care and excess profits for the contractor administering the program.[9] Still, a number of other States proceeded with their own HIO projects, designed to serve whole cities or counties.

Some people argued that the distinction HCFA created between HIOs and HMOs was fictitious. One type of HMO uses an "individual practice association" to furnish services; it contracts with individual physicians to treat HMO enrollees in their own offices, and it may allow any physician in the area to participate. If this organization were to contract with a State as an HMO, it would be subject to the requirement for disenrollment on demand and the 75 percent Medicare-Medicaid enrollment maximum. If it were relabeled an HIO, it would be exempt from these rules. Congress eliminated the distinction in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, Public Law 99-272); any HIO which accepted risk for a comprehensive range of services was subject to the same rules as an HMO. HIO projects already operational as of January 1, 1986, are permanently exempt from the HMO rules, and some projects under development on that date are exempt for the duration of their 1915(b) waivers, or no more than 2 years. States may still contract with the earlier type of HIO, which more closely resembles a fiscal intermediary, and which does not provide managed care. States' use of this option is discussed in Chapter VI.

The largest of the managed care HIO projects still in operation is HealthPASS, serving about 91,000 beneficiaries in part of Philadelphia. A December 1987 report on HealthPASS by the General Accounting Office indicated that, while the program appeared to be operating successfully, it was too early to comment on its long-range financial viability or its effect on quality of care.[10]

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[9] Freund, Deborah A. (with Polly M. Ehrenhaft and Marie Hackbarth). Medicaid reform: Four studies of case management. Washington. 1984. p. 53-6.

Paralleling the development of HIOs was a pair of experiments in California, in which public authorities were established in Monterey and Santa Barbara counties to serve area Medicaid beneficiaries. The county authority would be paid a premium by the State for each beneficiary and would in turn contract with physicians, hospitals, and other providers of service. These demonstrations faced financial losses and provider resistance, and only one remains in operation, the Santa Barbara Health Initiative.[11] (Unlike HIOs, county-operated programs may remain permissible under current law, which allows the Secretary to waive the 75 percent Medicaid enrollment maximum for public entities.)

4. MANDATORY HMO ENROLLMENT

Although TEFRA restricted the Secretary's ability to waive HMO requirements under the 1915(b) freedom-of-choice waiver authority, the Secretary could still waive these requirements under a different authority. Section 1115(a) of the Social Security Act allows the waiver of nearly all Medicaid requirements for the purpose of conducting a demonstration project. The Secretary used this authority to conduct a number of experiments under which all Medicaid beneficiaries, in a given geographic area or a whole State, were required to enroll in an HMO.

In 1982 Arizona, the only State that had never established a Medicaid program, began an experimental Medicaid program under a section 1115(a) demonstration waiver.[12] The Arizona Health Care Cost Containment System (AHCCCS, pronounced "access") is an acute care medical assistance program comparable to Medicaid for AFDC and SSI recipients, except that it does not offer a fee-for-service option. (Some medically needy persons are also served by AHCCCS, but there is no Federal funding for this component of the program.) In place of the usual open-ended Federal matching funds for service expenditures, AHCCCS receives a Federal per capita payment for each eligible beneficiary. The amount of the payment is negotiated with HCFA in advance. Counties make a contribution equal to a percentage of what they were spending for indigent care before 1982, and the State pays the remaining program costs.

Most beneficiaries are required to join an HMO contracting with AHCCCS (Indians eligible for care through the Indian Health Service are exempt). As of December 1987, 130,224 federally funded beneficiaries were enrolled in 14 organizations.[13] A combination of local and statewide contractors ensures that enrollees in most areas have at least two HMOs to choose from. Participants receive the mandatory Medicaid acute care services and some optional benefits. However, long-term care services are not provided and remain a county responsibility. (The State is seeking Federal financial participation in the long-term care program as well.)

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[10] U.S. Congress. General Accounting Office. Medicaid: Early Problems in Implementing the Philadelphia HealthPASS Program. Report to Congressional Requesters. Washington. December 1987. [GAO/HRD-88-37.]

[11] See Health Care Financing Administration. Health care financing extramural report: Nationwide evaluation of Medicaid competition demonstrations. Baltimore. 1986. [HCFA Pub. No. 03236] v. 2, Santa Barbara Health Initiative, and v. 3, Monterey County Health Initiative.

[12] Much of the following discussion is based on McCall, Nelda, et al. Evaluation of Arizona Health Care Cost Containment System. Health Care Financing Review, 9:2 (Winter 1987) p. 79-90.

[13] Health Care Financing Administration, unpublished report on prepaid enrollment.

Management of the AHCCCS program was initially contracted out to a private plan administrator. In the first year, there were administrative cost overruns, accompanied by reports of marketing, financial, and quality problems with some contractors. The State then took over direct management of AHCCCS, establishing a quality assurance system and other administrative controls. Although a 1987 GAO report found some continuing problems, chiefly in the area of rate setting, AHCCCS appears to be firmly established and has moved on to develop an insurance package for small employers.[14]

The AHCCCS demonstration waivers were renewed in 1985 but were due to expire in 1988. A provision of OBRA87 (Public Law 100-203) extends the current program through September 1989, and permits the Secretary to negotiate coverage of additional optional groups and payment for long-term care services, possibly on a prepaid basis.[15]

In 1982, the same year AHCCCS began, the Secretary granted a section 1115(a) waiver to Minnesota to allow mandatory HMO enrollment for beneficiaries in the Minneapolis area (the project did not actually become operational until 1985). More recently, the Secretary has allowed the use of section 2175, the freedom-of-choice waiver authority, to permit mandatory HMO enrollment programs. In three areas in Wisconsin, including Milwaukee and Madison, AFDC beneficiaries must select from among a number of participating HMOs. The beneficiaries may disenroll at 6-month intervals, but only to join another HMO. The Wisconsin project is part of a larger initiative, which also involved mandatory HMO enrollment by State employees.

HCFA has allowed mandatory enrollment arrangements so long as there are multiple HMO choices in the area and beneficiaries are permitted to transfer from one organization to another. This policy, if continued, would permit Arizona's AHCCCS project to convert to section 2175 status when its current statutory waiver expires in 1989.

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[14] U.S. Congress. General Accounting Office. Medicaid: Lessons learned from Arizona's prepaid program. Report to the Secretary of Health and Human Services. [Washington] March 1987. GAO/HRD-87-14.

[15] One unresolved issue relating to the AHCCCS program has been a dispute between Arizona and DHHS about AHCCCS responsibility for services to Indians. Medicaid programs must cover Indians who live on reservations and who meet Medicaid eligibility standards. Arizona contended that this requirement was one of the provisions waived by the Secretary for the purpose of the AHCCCS demonstration and that the Indian Health Service (IHS) was primarily responsible for the care of on-reservation Indians. (See Chapter IV for a discussion of the usual rules on Medicaid and the Indian Health Service.) The State has since acknowledged that AHCCCS is responsible for the care of categorically eligible Indians, those receiving AFDC or SSI, whether or not they live on reservations. It has continued to argue that IHS is primarily responsible for the medically needy, who are wholly State funded and therefore not subject to Federal Medicaid rules. The IHS position is that its services do not constitute an entitlement program and that the State program remains primarily responsible. This position has been sustained by the U.S. District Court (Arizona v. U.S., 1987). The case is under appeal.

5. SOCIAL/HMOS (S/HMOS) AND RELATED INITIATIVES [16]

Beginning in 1980, HCFA, DHHS, and private foundations worked to develop new systems for coordinating health care services furnished to the elderly, including Medicare beneficiaries and persons jointly eligible for Medicare and Medicaid. These systems, known as social/health maintenance organizations (S/HMOs), would be modeled after HMOs. However, S/HMOs would assume financial risk for long-term care services, including some nursing home care, in addition to the acute care services traditionally furnished by HMOs. The S/HMOs would have an incentive to provide expanded home health care and social services and to manage the care of their patients, in order to reduce the risk of nursing home admissions. S/HMOs would be funded with a combination of Medicare, Medicaid, and private premiums and would serve a mix of enrollees, from the healthy to the significantly impaired.

The Office of Management and Budget (OMB) objected to implementation of the S/HMO demonstrations because they involved the use of Medicare funds, intended for acute care, to help pay for long-term care.[17] OMB argued that the Medicare funds would simply replace existing Medicaid funding or would replace donated services by enrollees' families. The effect would be to shift costs, rather than to achieve actual savings.

Congress overrode OMB's objections and mandated the S/HMO projects in the Deficit Reduction Act of 1984 (Public Law 98-369, DEFRA). S/HMO projects began operation in 1985 in four cities: Minneapolis, Minnesota; Brooklyn, New York; Long Beach, California; and Portland, Oregon. The demonstrations were originally supposed to run for 3 years. However, the projects encountered delays in reaching their initial enrollment targets. OBRA87 extended the demonstration period through September 1992. An interim report on the projects is expected to be delivered to Congress in 1988.

In a parallel development, the Secretary in 1979 approved demonstration waivers for the On Lok program in San Francisco. Like the S/HMOs, On Lok receives premium payments from Medicare and Medicaid and assumes risk for both acute and long-term care. However, On Lok's enrollment is limited to the frail elderly at risk of nursing home care, as opposed to the mix of well and impaired persons enrolled by the S/HMOs. Congress mandated continued waivers for On Lok in the Social Security Amendments of 1983 (Public Law 98-21) and again in COBRA; the COBRA extension continues indefinitely unless On Lok ceases to comply with the conditions of its waivers. OBRA86 (Public Law 99-509) mandates waivers for up to 10 projects intended to replicate the On Lok program in other areas. Eligibility for this program was originally restricted to projects receiving funds from the Robert Wood Johnson Foundation. This requirement was deleted by OBRA87.

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[16] Much of the following discussion is drawn from Congressional Research Service. Financing and delivery of long-term care services for the elderly. [by Carol O'Shaughnessy and Richard Price] Washington. May 1988. CRS Report No. 88-379 EPW.

[17] Although the Secretary has the authority to approve demonstration projects, projects involving any reporting by grantees to the Government (as demonstrations necessarily do) are subject to OMB review under the Paperwork Reduction Act.

III. THE IMPACT OF MANAGED CARE

A. Current Status of Managed Care

States' interest in pursuing managed care initiatives may have reached its peak in the 1981–83 period, when a combination of rising Medicaid costs, a recession, and the temporary OBRA81 limits on Federal matching funds combined to place increasing pressure on States to find innovative cost saving approaches. Of the 25 managed care waivers approved by HCFA under section 2175 from 1981 through February 1988, 17 date from those first 3 years. As Tables V–1 and V–2 in Chapter V indicate, later years have seen a marked decline in new initiatives, and a number of the early programs are no longer in operation. The only approach which has seen steady and continuous growth from 1981 to the present has been HMO contracting, and much of this growth has occurred in States that had already dealt with HMOs prior to 1981.

At least two major factors might account for States' increasing caution in undertaking new managed care programs.

First, there has been some moderation of the fiscal pressure that caused States to explore managed care alternatives. The rapid growth in Medicaid expenditures that began in the late 1970's slowed somewhat in the middle 1980's. The 1981 cuts in Federal Medicaid cost sharing were not renewed after their initial 3-year period. While they lasted, States found other ways to achieve more immediate savings than were available from managed care, including changes in hospital and nursing home reimbursement systems and utilization control measures, such as requirements for preauthorization of inpatient services.

Second, managed care programs proved more difficult to implement than some States had initially thought. Some of the fee-for-service case management programs faced problems with beneficiary and provider confusion and consequent allegations of reduced access to care. More highly structured arrangements for Medicaid beneficiaries were costly to develop and now face legal barriers. The most easily implemented choice still open to States is expanded contracting with existing HMOs. However, established organizations in many areas may still be reluctant to consider a Medicaid contract for the reasons cited earlier.

Still, a number of States continue to work towards expanded managed care programs. How well has managed care worked? This question breaks down into two issues: whether managed care programs have actually achieved savings, and what impact they have had on access to health services and quality of care.

B. Cost Savings

Managed care systems have been shown to achieve savings, relative to traditional fee-for-service insurance programs, in a number of studies. The best known of these is the Health Insurance Study conducted by the Rand Corporation in Seattle in the late 1970's. Families agreeing to participate in the study were randomly assigned to an HMO, the Group Health Cooperative of Puget Sound, or to a comprehensive insurance program. Persons assigned to the HMO used 40 percent fewer inpatient hospital days, and their overall estimated costs were 25 percent lower than those for persons assigned to the conventional insurance plan.[18]

While the Rand study demonstrated the capacity of an HMO to reduce utilization and costs in a controlled, experimental situation, demonstrating cost savings outside the experimental setting has proved more difficult. Reliable evaluations of Medicaid managed care projects are only just beginning to appear.

The issue of cost savings appears fairly simple in HMOs or other prepaid systems. Medicaid programs have generally based the premium rates for HMOs on estimates of what would have been spent for a comparable group of beneficiaries not enrolled in the HMO. A State might, for example, estimate that average costs for an adult AFDC beneficiary outside the HMO are $100 a month; it might then pay the HMO 95 percent of this amount, or $95. If the State's estimates were correct, it would presumably save $5 a month for each enrollee.

This will be true, however, only if the beneficiaries enrolled in the HMO are identical in health status and need for health services to the beneficiaries on whose experience the State's estimate was based. If the persons joining the HMO are unrepresentative of the total population, either sicker or healthier, then the State's savings may be more or less than the apparent $5. The possibility that this will occur is known as "biased selection." [19] The problem of biased selection has been a central issue in discussion of HMOs for many years. Some people say that healthier people join HMOs, because sick people have established ties to their own physicians and don't want to give up their choice of providers. Others say that sicker people join HMOs, because of the ready access to comprehensive health services.

The Rand study cited earlier corrected for this problem by randomly assigning the participants, so that there was no difference between the beneficiaries in the HMO and those in the ordinary insurance plan. The Rand Corporation is currently attempting a new set of randomized assignment experiments for Medicaid beneficiaries in New York and Florida in conjunction with a HCFA initiative, the Program for Prepaid Managed Health Care. Results of these demonstrations will not be available for several years. In the interim, two approaches to measurement of cost savings have been used.

The first approach is actually to attempt to measure the differences between beneficiaries joining a managed care program and those remaining in the traditional Medicaid system. One way of doing this is to examine the utilization and costs of the beneficiaries before they joined the managed care program, to see if the enrollees used more or fewer services than beneficiaries who didn't join. A study in Michigan in 1977–78 concluded that biased selection had in fact occurred. HMO enrollees were less likely to have used health care services before joining the HMO than comparable beneficiaries who didn't enroll.[20] A more recent study, also in Michigan, examined the fee-for-service case management Physician Primary Sponsor Plan. This study adjusted for preenrollment use of services and found substantial cost reductions from the case management approach. Estimated savings in 1984 were 13 percent for all Medicaid beneficiaries enrolled, and 21 percent for those in the AFDC group.[21]

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[18] Manning, Willard G., et al. A controlled trial of the effect of a prepaid group practice on use of services. New England Journal of Medicine, 310:23 (June 7, 1984), p. 1505–1510.

[19] Two kinds of biased selection may occur: adverse selection, the enrollment of persons sicker than average, and favorable selection, the enrollment of persons healthier than average.

The second approach is to evaluate savings in the systems which mandate enrollment by all beneficiaries. Because everyone, healthy or sick, is enrolled in the system, biased selection ceases to be an issue. It is then possible to compare the beneficiaries' use of services before and after entering the managed care system, in order to determine whether managed care made any difference. This approach is being used in evaluations of several managed care programs operated under section 1115(a) demonstration waivers as part of a HCFA "Medicaid competition" initiative. Although the investigators report that their preliminary findings show substantial utilization reductions and probable cost savings, no published results are yet available.[22]

One possible problem with this kind of study is that there is no comparison group left outside the managed care program. Estimates of savings depend on assumptions about what would have happened to Medicaid expenditures in the same geographic area if the managed care system had not been implemented. The comparison is between the managed care program and the essentially uncontrolled Medicaid system which preceded it. This may leave unresolved a question which is beginning to receive attention at both the State and the Federal level. Can managed care achieve savings over and above the savings realized from some of the other cost containment approaches adopted in the 1980's? If a Medicaid program has adopted prospective payment for hospital services and a strict fee schedule for physicians, or if it uses preauthorization of services and other utilization control measures, can it be expected that a managed care program will cut costs even further?

Some people say that there are limits to how much managed care can save without endangering quality. They suggest that managed care should be regarded as an alternative to other cost containment approaches, rather than as a way of obtaining even further savings. Others argue that there remains considerable inefficiency in the fee-for-service sector and that further evaluation is needed to determine the full savings potential of managed care.

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[20] DesHarnais, Susan I. Enrollment in and disenrollment from health maintenance organizations by Medicaid recipients. Health Care Financing Review, 6:3 (Spring 1985), p. 39–50.

It should be noted that there are also studies of biased selection into managed care systems for groups other than Medicaid, such as Medicare beneficiaries or private employee groups. However, members of these groups, unlike Medicaid beneficiaries, contribute to the cost of their own care. Their reasons for enrolling may be different from those of Medicaid beneficiaries, and studies of their enrollment tendencies may therefore not be generalizable to Medicaid.

[21] Smith, Vernon. Michigan's Physician Primary Sponsor Plan. In National Governors' Association, Center for Health Policy Studies, Facilitating health care coverage for the working uninsured: Alternative State strategies. Washington. 1987. p. 93–4.

[22] Personal communication, Deborah A. Freund, Associate Professor, University of North Carolina.

C. ACCESS AND QUALITY OF CARE

The potential impact of managed care programs on access to health services and quality of care has been the subject of debate ever since HMOs first received wide publicity in the 1970's. If the traditional fee-for-service program encouraged overutilization of services, it was feared, the incentives under managed care to treat patients more efficiently might lead to underutilization and denial of needed treatments. Proponents of managed care responded that satisfactory health care outcomes could be achieved with fewer resources—fewer tests, fewer hospital admissions—than traditional medicine provided. They pointed out that overtreatment, such as unnecessary surgery, also posed dangers to patients.

Attempts to determine whether care in managed programs, especially HMOs, was better or worse than care in the fee-for-service system have produced no consistent results. If a consensus has developed, it is that there are variations in quality among managed care providers, just as there are among providers in the fee-for-service sector. In established HMOs treating the general population, health care outcomes do not appear to differ significantly from those obtained by fee-for-service providers.[23]

There are concerns, however, that Medicaid beneficiaries may not always fare as well in managed care systems as the general population does. As in the area of cost savings, the major study on this subject is a product of the Rand Health Insurance Study, which randomly assigned participants to an HMO and a fee-for-service insurance program. In each group, participants were divided into four subgroups according to income (low or high) and whether they had health problems at the outset of the study. On a variety of health outcome measures, such as blood pressure, serum cholesterol level, and overall physical functioning, three of the four subgroups did about as well in the HMO as in the fee-for-service program. One group, the low-income participants with existing health problems, did worse. Their health status at the conclusion of the study was significantly poorer than that of comparable persons in the fee-for-service program.[24]

The investigators speculate that the low-income enrollees might have had difficulty dealing with the bureaucracy of an HMO, and argue that outreach and social services are needed to help low-income patients use an HMO system. As they acknowledge, the HMO in the study actually provided such services to its ordinary Medicaid enrollees, but not to the participants in the study. One other feature of the study may limit its applicability to other Medicaid managed care programs. The participants assigned to the non-HMO option had an insurance plan which paid providers' full fees, rather than the reduced reimbursement levels prevailing under Medicaid (see Appendix G). The investigators suggest that the non-HMO low income group might have enjoyed greater access to services than would have been the case under regular Medicaid. The study may, then, somewhat exaggerate the real differences in outcomes for managed care and fee-for-service options under Medicaid.

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[23] For a recent review of the literature on this subject, see Glenn T. Hammons et al. Selected alternatives for paying physicians under the Medicare program: Effects on the quality of care. [Santa Monica] 1986. Prepared for the Office of Technology Assessment. (Rand Note No. R-3394-OTA)

[24] Ware, John E., Jr., et al. Comparison of health outcomes at a health maintenance organization with those of fee-for-service care. Lancet, May 3, 1986, p. 1017-1022.

Still, growing concerns about the quality of services furnished by HMOs (generated in part by reports of problems in the Medicare HMO contracting program) led Congress to enact stricter requirements in OBRA86 and the Medicare Catastrophic Protection Act of 1988 (Public Law 100–360). While States have always been required to conduct some form of review of HMO services, they must now contract with a peer review organization (PRO) or other independent accrediting body for an outside assessment of Medicaid prepaid contractors. In addition, HMOs may now be subject to civil monetary penalties if they deny medically necessary care, overcharge beneficiaries, discriminate in enrollment on the basis of health status, or provide false information to the Secretary, the State, or any other individual or entity. (See Chapter V for further details on these provisions.)

Finally, beginning in April 1990 HMOs participating in either Medicaid or Medicare will be subject to civil monetary penalties for making incentive payments to physicians to reduce the services provided to enrollees (the original deadline of April 1989 was changed by OBRA87). Critics of physician incentive plans believe that in some cases physicians may respond to financial pressure, not just by improving efficiency, but also by denying or delaying necessary services. Others note that physician incentive plans have been a common practice in HMOs for many years. They argue that some form of financial incentive is necessary as a corrective to the tendency, under the fee-for-service system, to maximize the quantity of services delivered. The Secretary was required to recommend alternatives to an absolute prohibition of incentive plans by January 1988; the recommendations have been delayed but are still expected in 1988.

APPENDIX G. PROVIDER PARTICIPATION IN MEDICAID [1]

INTRODUCTION

SUMMARY

While Medicaid has improved access to medical care for many low-income persons, critics of the program contend that there are still barriers to care and that Medicaid has failed to bring its beneficiaries into the mainstream of the health care system. This appendix reviews evidence on the extent of participation in the Medicaid program by three types of providers: physicians, hospitals, and nursing homes.

Physicians. The willingness of physicians to accept Medicaid patients varies by specialty. Surgical specialists and primary care physicians are most likely to accept Medicaid, while obstetricians and psychiatrists are the least likely. Low Medicaid fee schedules, relative to the physicians' usual charges to other payers, are the major deterrent to participation. Physicians may also be influenced by what they perceive as cumbersome bureaucratic requirements, delays in claim payment, or characteristics of Medicaid beneficiaries themselves. Physicians in areas with a high concentration of Medicaid beneficiaries are more likely to participate, and some studies have found higher participation among physicians who are younger, who are certified by specialty boards, or who believe that society should ensure that medical care is available to all.

Studies in the late 1970's found that Medicaid physician payment rates were equal to 70 to 75 percent of private fees for equivalent services. More recent data suggest that the gap between Medicaid and private rates may have widened somewhat. However, there is considerable variation among States. States that base their payments on providers' prevailing charges appear to have at least kept pace with Medicare reimbursement for comparable services. States that use fixed fee schedules have not.

Hospitals. Virtually all hospitals participate in Medicaid. However, the extent of participation varies widely. For inpatient services, Medicaid beneficiaries are much more likely to be treated in public non-Federal hospitals than are other patients, and are less likely to be admitted to private for-profit facilities. They are slightly less likely than other patients to be admitted to private nonprofit hospitals. The patterns are very similar for outpatient care, except that for-profit facilities provide an even smaller proportion of Medicaid outpatient services than of inpatient services. Finally, teaching hospitals have a higher Medicaid patient load than others, although this factor is less significant than ownership. Within each of the categories of hospitals, the distribution of Medicaid patients is uneven. A small number of hospitals have large shares of Medicaid patients; the rest have relatively few.

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[1] This appendix was written by Mark Merlis.

Physicians have reported in surveys that some facilities are actively discouraging admission of Medicaid patients, and studies of patients transferred from other hospitals to public hospital emergency rooms indicate that some hospitals may be turning away Medicaid beneficiaries in need of urgent care. Factors other than hospital admission policies, such as location or the nature of the hospital's services, may affect a hospital's Medicaid caseload. At least in some States, however, hospitals may be reluctant to admit Medicaid patients because of Medicaid reimbursement rates or coverage policies. The relative adequacy of Medicaid hospital reimbursement is difficult to determine. While daily Medicaid rates in many States are lower than the reported average daily cost of hospital care, Medicaid patients may be using higher or lower cost facilities, and have been found to have lower cost illnesses or conditions than other patients. The potential effect of coverage rules is clearer; fixed limits on the number of days the Medicaid program will pay for, along with other utilization controls, may place hospitals at risk of receiving no payment for some part of a Medicaid patient's stay.

Some hospitals treat a high share of both Medicaid and uninsured patients. The financial losses resulting from uncompensated care may be compounded if the hospital's Medicaid reimbursement is below the hospital's actual costs for treating Medicaid patients. This problem may be partially alleviated by recent changes in Medicaid law, which strengthen existing requirements that States offer enhanced reimbursement to hospitals treating a "disproportionate share" of Medicaid and uninsured patients.

Nursing homes. Medicaid is the most important source of coverage for nursing home services; the enactment of Medicaid contributed to the rapid growth in the nursing home industry in the 1960's and 1970's. However, there are reports by Medicaid administrators and others that some Medicaid beneficiaries face problems in obtaining access to nursing home services. Medicaid's share in national nursing home expenditures has dropped from a peak of 48.6 percent in 1979 to a low of 41.4 percent in 1986. The proportion of the total nursing home population receiving Medicaid during the same period has been rising. However, many of these patients entered the home with some other source of payment and became eligible for Medicaid only after exhausting their resources. In addition, much of the growth in the Medicaid nursing home population is apparently attributable to longer stays for each beneficiary served, rather than to an increase in the number of beneficiaries served.

Concerned that Medicaid nursing home expenditures would rise as long as new nursing home beds became available, many States took advantage of Federal health planning programs to limit new construction during the 1970's and early 1980's. As a result, the bed supply has grown more slowly than the aged population. Of the beds that do exist, 13 percent are not certified for participation in Medicaid. The limited bed supply and growing occupancy rates have meant that nursing homes in some areas are in a position to select the most profitable patients: those for whom the highest reimbursement is available and who require the least intensive care. Medicaid beneficiaries are potentially at a disadvantage in the competition for nursing home placements. On average, Medicaid nursing home rates nationally are lower than the rates charged to self-pay patients or to Medicare. A comparison at the individual facility level suggests that Medicaid reimbursement is more nearly competitive with that of other payers for intermediate care facilities (ICFs) and is generally not as competitive for skilled nursing facilities (SNF).

Overall, the data do not permit firm conclusions on the issue of whether Medicaid beneficiaries are systematically excluded from nursing homes on a national basis. However, there are numerous reports of discrimination in individual cases. Some nursing homes have been found to engage in a variety of practices intended to limit their Medicaid caseloads. Many of these practices are now illegal. Nursing homes may not expel private pay patients who exhaust their funds and become Medicaid eligible. They may not require patients' relatives to make up the difference between Medicaid and private rates. Nor may they require "private pay contracts," under which a relative promises that the patient will not apply for Medicaid during a fixed period and guarantees payment for that period.

Nursing homes in most States still may refuse to admit Medicaid beneficiaries and at the same time accept Medicaid payments for patients admitted as private pay who exhaust their resources. Only two States, Connecticut and Maine, have forbidden this practice; several others have taken less stringent measures to encourage open admission policies.

LEGAL CONTEXT

The Medicaid program was originally designed as an expansion of existing Federal-State programs of medical assistance for low income persons, including the 1960 Kerr-Mills program for the aged and the "vendor payment" medical care programs, which were funded through the cash assistance programs (AFDC and aid to the aged, blind, and disabled) from 1950 on. Under the pre-Medicaid vendor payment programs, a State could (a) furnish the equivalent of health insurance, paying claims for services obtained by beneficiaries from providers of their choice, or (b) contract with specific providers, such as clinics or hospitals, to serve as the sources of care for public assistance recipients. As enacted in 1965, Medicaid continued to allow States the option of making direct arrangements for beneficiaries' care.

The Social Security Amendments of 1967 (Public Law 90–248) provided that Medicaid beneficiaries had to be permitted to obtain covered services from any qualified provider "who undertakes to provide [the beneficiary] such services." The so-called "freedom of choice" requirement meant that States could no longer establish special clinics for welfare clients or require all beneficiaries to use county hospitals. Instead, Medicaid would allow low-income citizens to use providers of their choice, to enter the mainstream of American health care.

Whether they could actually do so depended on whether providers were prepared to participate in the program. Medicaid law itself imposes no such requirement, although some other Federal and State laws may oblige certain types of providers to accept Medicaid patients. For example, hospitals, nursing homes, and other facilities constructed with Federal grants under the Hill-Burton Act must agree to participate in Medicaid. Similarly, States that require a certificate of need (CON) before a new hospital or nursing home is built may condition the granting of the CON on an agreement that the facility will accept Medicaid patients.

Medicaid law and regulations require States to consider access to providers in establishing their reimbursement rates. Rates for all providers must be "sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population." (42 CFR 447.204) For hospitals, the law requires that rates be at levels that "assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality."

While Medicaid has improved access to medical care in general,[2] there are continuing claims that the goal of mainstreaming has not been achieved. Critics of the program contend that beneficiaries face a dual class system of medical care, that they are able to obtain ambulatory services chiefly from a limited group of Medicaid-oriented providers and must turn to public hospitals for inpatient care. Finally, there are concerns that Medicaid beneficiaries in some areas have difficulty obtaining admission to nursing homes.

I. PHYSICIANS

Inadequate access to physician services is one of the most frequently cited criticisms of the Medicaid program. Because of low Medicaid fees and the consequent refusal of office-based physicians to accept Medicaid beneficiaries, it is argued, the beneficiaries must seek care in hospital outpatient departments, emergency rooms, or public clinics—or must forgo care altogether.

Services in hospital outpatient departments do account for a disproportionate amount of total Medicaid acute care spending. The ratio of Medicaid physician to Medicaid outpatient expenditures in 1986 was about 5:4. The equivalent figure for Medicare is nearly 4:1.[3] The disparity does not hold equally in all parts of the country. In the Northeast, outpatient expenditures significantly exceed those for physician services; the reverse is true in other regions.

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[2] Davis, Karen. Medicaid Payments and Utilization of Medical Services by the Poor. Inquiry, 13:2 (June 1976), p. 122–135. For more recent evidence see Kasper, Judith D. Health Status and Utilization: Differences by Medicaid Coverage and Income. Health Care Financing Review, 7:4 (Summer 1986), p. 1–17.

[3] Note, however, that Medicare pays separately for the physician component of outpatient services, while some Medicaid agencies include the physician component in the hospital's payment.

That Medicaid patients are more likely to use hospital-based physician services does not necessarily mean that they are receiving less ambulatory care overall.[4] However, there are concerns that use of outpatient departments results in a lack of continuity, and that an inability to establish ongoing ties with a single physician may produce negative outcomes. In addition, hospital outpatient services may be more costly than equivalent services provided by office-based physicians. This point is open to debate, at least with regard to services other than those in emergency rooms.[5]

Whatever the effects of hospital-based care, the continued reliance on outpatient departments does suggest to some observers that Medicaid beneficiaries may not have access to the physicians used by the rest of the population, at least in some parts of the country. Others say that the use of hospital-based services cannot be attributed solely to the absence of community alternatives, but may also reflect patterns of care-seeking behavior on the part of the beneficiaries themselves, patterns that were established long before the enactment of Medicaid. (The regional differences in outpatient utilization noted above may also be partially attributable to differences in historical patterns of delivery of care to the poor.) The possibility of changing these behavior patterns has been an important source of State interest in the managed care alternatives described in Appendix F. The remainder of this discussion, however, focuses on the extent of participation by independent practitioners and on possible explanations for physicians' decisions to accept or refuse Medicaid patients.

A. LEVELS OF PHYSICIAN PARTICIPATION

Evidence on physician participation in Medicaid is fragmentary and frequently anecdotal. States do collect and report to HCFA annual counts of participating physicians. However, a physician is considered as "participating" if he or she submits even a single claim for services to a Medicaid beneficiary during a year; the extent of participation is not measured in the data. In addition, some States' physician counts fail to distinguish between individual practitioners and groups. A multispecialty group with 100 physicians could be reported as a single physician provider. For these reasons, national data on physician participation in Medicaid are not helpful for analysis of access. Instead it is necessary to rely on published studies of small samples of physicians.

Most studies of Medicaid physician participation have used surveys, particularly a series of surveys conducted by the National Opinion Research Center (NORC) under contract to HCFA in 1977 and 1978. Physicians in the NORC/HCFA sample were asked whether they accepted Medicaid payment and what proportion of their practice was made up of Medicaid patients. There have been a few more recent national surveys of practitioners in specific specialties, including one of pediatricians in 1983 and another in the same year of physicians providing reproductive health services. However, the NORC/HCFA studies were the last to include all types of physicians.

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[4] One study suggests that low Medicaid reimbursement rates shift Medicaid beneficiaries from office-based to hospital physicians without reducing overall use of physician services. Long, Stephen H., Russell F. Settle, and Bruce C. Stuart. Reimbursement and Access to Physicians' Services under Medicaid. Journal of Health Economics, 5 (1986), p. 235–251.

[5] Medicaid programs have paid office-based physicians according to a fee schedule while, until very recently, paying hospitals their full costs. It is not clear that the price difference for equivalent services would have been so great if Medicaid had paid office-based physicians' full charges. In addition, some hospitals suggest that the patients seen in outpatient departments are more seriously ill than those treated in physicians' offices.

Table G–1 shows the percent of physicians responding to the NORC/HCFA surveys who said they ever accepted Medicaid payment and, for those who accepted Medicaid, the average percentage of their case load that they estimated was made up of Medicaid patients. Surgical specialists and primary care physicians were most likely to accept Medicaid and psychiatrists the least likely, with medical specialists (such as cardiologists and dermatologists) in between.

Table G–1.—PHYSICIAN PARTICIPATION IN MEDICAID, 1977–78

	Percent accepting any Medicaid patients	For those accepting Medicaid, Medicaid as percent of total practice
Primary care	77.5	12.7
General practice	75.1	13.1
General surgery	90.3	13.4
Internal medicine	79.8	13.2
Obstetrics/gynecology	64.4	8.4
Pediatrics	76.9	14.1
Medical specialties	73.4	8.8
Allergy	77.1	7.8
Cardiology	68.1	6.9
Dermatology	72.9	11.2
Gastroenterology	81.1	9.2
Surgical specialties	82.9	12.2
Neurosurgery	84.8	10.6
Ophthalmalogy	82.0	13.2
Orthopedic surgery	81.4	9.8
Otolaryngology	83.7	13.9
Urology	88.9	13.2
Psychiatry	57.8	8.0

Source: Mitchell, Janet B. and Rachel Schurman. Access to Private Obstetrics/Gynecology Services Under Medicaid. Medical care, v. 22, no. 11, Nov. 1984. p. 1028. [Data based on HCFA/NORC physician surveys, 1977–8]

Moreover, psychiatrists and medical specialists who did accept Medicaid reported that Medicaid accounted for a smaller part of their practice than was the case for participating surgical specialists and primary care physicians.[6] For some of the specialties, this might be expected. For example, cardiologists might tend to treat older patients. The older Medicaid beneficiaries most likely to use their services would tend to be the dually eligible, with Medicare as their primary source of payment. One researcher has offered other explanations for the generally lower participation by medical as opposed to surgical specialists. Surgeons may have lower overhead costs than medical specialists, because so much of their work is done in hospitals, and so they may be more willing to accept reduced reimbursement rates. Hospitals that accept Medicaid patients may pressure their attending surgeons to participate as well.[7]

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[6] All the physicians' estimates of the Medicaid share of their practice must be interpreted with caution. A recent comparison of such estimates, made during a 1979 and 1980 NORC study, with actual patient records during the survey period found that the physicians tended to overstate the Medicaid share of their practices by 40 percent. Kletke, Phillip R., et al. The Extent of Physician Participation in Medicaid: A Comparison of Physician Estimates and Aggregated Patient Records. Health Services Research, 20:5 (December 1985), p. 503–523.

Obstetricians/gynecologists were, after psychiatrists, the least willing to accept Medicaid, even in 1977, before the malpractice crisis which is sometimes said to have affected obstetricians' Medicaid participation (but after an earlier malpractice crisis in the 1970's). Data do not confirm the view that Medicaid beneficiaries are more likely than other patients to file malpractice claims, either against physicians in general or against obstetricians.[8] However, if Medicaid payment rates were below a physician's usual charges, the physician might conclude that the assumed risk per dollar received was greater for Medicaid patients.

A more recent survey of physicians in several specialties likely to furnish reproductive health services (including general/family practitioners, general surgeons, and urologists, as well as obstetricians) suggests that there may have been some further decline in participation since 1977.[9] Table G–2 shows the results. Of the 51 percent of the surveyed physicians who were performing deliveries in 1983, only 56 percent would accept Medicaid reimbursement for this service. (Note, however, that participation rates were roughly equivalent for other kinds of reproductive health services as well. The data do not support the hypothesis that physicians were curtailing Medicaid deliveries while continuing to furnish other kinds of services to beneficiaries.)

Table G–2.—AVAILABILITY OF REPRODUCTIVE HEALTH SERVICES, 1983

Type of service	Percent of physicians in relevant specialties providing service [1]	Of these, percent who accept Medicaid for the service
Obstetric care	51	56
Contraception	89	56
Female sterilization	37	58
Vasectomy	38	51
Infertility care	45	47
Prenatal genetic screening	46	50

[1] Specialties included are general/family practice, general surgery, obstetrics/gynecology and urology.

Source: Orr, Margaret T., and Jacqueline D. Forrest. The Availability of Reproductive Health Services from U.S. Private Physicians. Family planning perspectives, 17:2 (Mar/Apr 1985). Tables 1 and 7.

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[7] Mitchell, Janet B. Medicaid Participation by Medical and Surgical Specialists. Medical Care, 21:9 (Sep. 1983), p. 929–938.

[8] A General Accounting Office study of malpractice claims found that Medicaid patients accounted for 5.8 percent of claims for which a patient insurance source could be identified. U.S. Congress. General Accounting Office. Medical Malpractice. Characteristics of Claims Closed in 1984. Washington. April 1987. [GAO/HRD–87–55] A survey of obstetrician-gynecologists providing fertility-control services found that those who accepted Medicaid patients were no more likely than those who did not to have been faced with threatened or actual lawsuits. Weisman, Carol S., Martha Ann Teitelbaum, and Laura L. Morlock. Malpractice Claims Experience Associated with Fertility-Control Services among Young Obstetrician-Gynecologists. Medical Care, 26:3 (Mar. 1988), p. 298–306.

[9] Orr, Margaret T., and Jacqueline D. Forrest. The Availability of Reproductive Health Services from U.S. Private Physicians. Family Planning Perspectives, 17:2 (Mar/Apr 1985), p. 63–69.

Participation in other specialties may not have declined as significantly. The 1983 survey of pediatricians found only a 0.07 percent drop in participation rates nationally between 1978 and 1983. However, the decline was much more significant in a few States, probably because Medicaid reimbursement levels failed to keep pace with private fees.[10]

Finally, there appear to be regional differences in physician participation. One study found that, overall, primary care physicians in the South were the least likely to accept Medicaid, those in the West the most likely.[11] This may reflect regional variations in the factors that affect physician participation; these are the subject of the next section.

B. Factors in Physician Participation

Most of the participation studies have collected information on the physicians' training and attitudes, their practices, and the competitive environments in which they practiced, in order to identify possible factors in physicians' decisions about accepting Medicaid and about the number of patients they would accept.

Many investigators have sought to test a "dual market" model for participation, under which physicians enter the Medicaid market only if there is sufficient competition in the private market.[12] If Medicaid patients were less desirable than other kinds of patients, because of lower reimbursement levels or for other reasons, physicians would take the other patients first. Medicaid participation would increase if physician supply increased. Physicians in a highly competitive situation would have fewer of the more desirable patients to go around and would begin accepting Medicaid. Some elements of this model have been supported by the evidence, while others have not.

1. PATIENT DESIRABILITY

It has been shown repeatedly that Medicaid reimbursement levels—or, more precisely, the gap between Medicaid reimbursement and what a physician can obtain from other payers—have a significant effect on participation.[13] Other factors may also work to make Medicaid patients more or less acceptable. Physicians have been found to refuse Medicaid patients because they find dealing with program administration cumbersome or because Medicaid takes too long to pay bills. Participation was higher in States that paid claims promptly or that used independent fiscal agents as intermediaries between providers and the Medicaid agency. Physicians may also be frustrated by Medicaid coverage restrictions or authorization requirements, which may be regarded as interfering with the physician's professional judgment. Finally, there has been speculation that some characteristics of Medicaid beneficiaries may make them less acceptable to some providers. Physicians may find that Medicaid patients take more time and require more support services than others, or that they are less compliant with medical advice.[14]

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[10] Perloff, Janet D., Phillip R. Kletke, and Kathryn M. Neckerman. Medicaid and Pediatric Primary Care. Baltimore. 1987.

[11] Mitchell, Janet B., and Rachel Schurman. Access to Private Obstetrics/Gynecology Services under Medicaid. Medical Care, 22:11 (Nov. 84), 1026–1037.

[12] See Perloff, Kletke, and Neckerman, op.cit., p. 17–19, for a summary of this model.

[13] Hadley, Jack. Physician Participation in Medicaid: Evidence from California. Health Services Research 14:4 (Winter 1979), p. 266–280. Mitchell and Schurman, op.cit., p. 1030–1032.

2. COMPETITION

The evidence is much less clear on the second major component of the market model, the hypothesis that Medicaid participation would increase if physicians faced heavy competition for other kinds of patients. Studies have repeatedly found that, as the ratio of physicians to the general population in a given county or metropolitan area rises, the extent of Medicaid participation drops.[15] However, the few studies which have looked below the county level have also found a strong correlation between a physician's willingness to accept Medicaid patients and the number of Medicaid beneficiaries in the zip code where the physician's practice is located. Taken together, the two findings may suggest that each physician in a highly competitive area does not add a Medicaid component to his or her practice to make up for a declining pool of private patients. Instead, some observers have noted, competition may lead physicians to specialize in one market or the other.[16] The extent to which this specialization may be related to simple geographic distribution, the presence or absence of physicians in areas with a high concentration of Medicaid beneficiaries, has not been systematically studied.

3. OTHERS

Some other apparent factors in participation have been identified that do not fit readily into the dual-market model. Characteristics of individual physicians may have an impact. Some studies have found higher participation among physicians who are younger, who are certified by specialty boards, and who believe that society has a responsibility to ensure that medical care is available.[17] Finally, primary care physicians who are graduates of foreign medical schools are somewhat more likely to accept Medicaid patients and significantly more likely to have a high proportion of Medicaid patients. No such correlations were found for foreign medical graduates who were specialists, rather than primary care physicians.[18]

C. REIMBURSEMENT LEVELS

Whether or not they support hypotheses about how the market for physician services functions, the studies of Medicaid participation decisions do generally agree that reimbursement levels are a fundamental factor. How does Medicaid reimbursement for physician services actually compare to physicians' usual charges or to what they are paid by other insurers? In the NORC/HCFA surveys and similar studies, physicians have tended to report that Medicaid payment was equal to about 70 to 75 percent of their private fees for equivalent services. (Whether the surveyed physicians always received their full private fees from other payers is not clear.) However, most of these figures date from the late 1970's. The gap might have grown or narrowed during the intervening years, depending on whether Medicaid payments kept pace with private market prices. In addition, national survey data cannot show the variation among States.

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[14] Davidson, Stephen M. Physician Participation in Medicaid: Background and Issues. Journal of Health Politics, Policy and Law, 6:4 (Winter 82), p. 703–717. Sloan, Frank, Janet Mitchell, and Jerry Cromwell. Physician Participation in State Medicaid programs. Journal of Human Resources, 13 (1978 Supplement), p. 211–245.

[15] Mitchell; Hadley; Perloff, Kletke, and Neckerman.

[16] Perloff, Kletke, and Neckerman, op.cit., p. 54–57.

[17] Mitchell; Perloff, Kletke, and Neckerman.

[18] Sloan, Mitchell and Cromwell, op.cit.

The only readily available basis for State by State comparison is the Medicare allowable charge for comparable services. Tables G–3 and G–4 compare maximum fiscal year 1986 Medicare and Medicaid payments, by State, for two common physician services, a brief followup office visit and an appendectomy. The Medicaid maximums are statewide averages reported by States in a HCFA survey (it is not known which, if any, States actually have different maximums in different parts of the State). The Medicare maximums are the highest allowable charge anywhere in the State during the first part of fiscal year 1986; lower amounts may have been allowed in some parts of the State. For some States, Medicare figures were not available for all parts of the State. Note that the maximums shown for both Medicaid and Medicare are those for specialists. In many States, there is a lower Medicare maximum for general practitioners' services; only a few Medicaid programs make this distinction.

Table G–3.—MEDICAID MAXIMUM PAYMENTS AND MEDICARE MAXIMUM ALLOWABLE CHARGES, SPECIALISTS, 1986

	Brief followup office visit (CPT code 90040)		
	Medicaid [1]	Medicare [2]	Medicaid as percent of Medicare
Alabama	$11.70	$20.70	56.5
Alaska	28.41	24.70	115.0
Arkansas	12.00	14.40	83.3
California	11.04	30.00	36.8
Colorado	11.75	15.50	75.8
Connecticut	[3] 8.80	24.80	35.5
Delaware	12.66	21.00	60.3
District of Columbia	20.00	[4] 25.00	90.9
Florida	10.00	24.80	40.3
Georgia	15.60	15.00	104.0
Hawaii	13.25	16.50	80.3
Idaho	10.50	14.60	71.9
Illinois	11.50	25.00	46.0
Indiana	17.30	16.50	104.8
Iowa	N/A	30.00	N/A
Kansas	15.00	16.70	89.8
Kentucky	13.00	16.50	78.8
Louisiana	10.69	16.30	65.6
Maine	8.00	N/A	N/A
Maryland	10.50	22.00	47.7
Massachusetts	8.00	N/A	N/A
Michigan	7.75	23.50	33.0
Minnesota	15.75	N/A	N/A
Mississippi	11.55	N/A	N/A

Table G–3.—MEDICAID MAXIMUM PAYMENTS AND MEDICARE MAXIMUM ALLOWABLE CHARGES, SPECIALISTS, 1986—Continued

	Brief followup office visit (CPT code 90040)		
	Medicaid [1]	Medicare [2]	Medicaid as percent of Medicare
Missouri	10.00	20.70	48.3
Montana	11.30	14.70	76.9
Nebraska	16.30	16.30	100.0
Nevada	15.82	24.70	64.0
New Hampshire	6.00	12.40	48.4
New Jersey	9.00	20.60	43.7
New Mexico	11.50	17.20	66.9
New York	[3] 7.00	[5] 20.60	34.0
North Carolina	13.10	16.50	79.4
North Dakota	8.20	12.40	66.1
Ohio	12.00	20.60	58.3
Oklahoma	11.00	20.70	53.1
Oregon	11.07	18.50	59.8
Pennsylvania	13.00	25.00	52.0
Rhode Island	14.00	20.63	67.9
South Carolina	9.50	14.62	65.0
South Dakota	12.00	12.40	96.8
Tennessee	18.00	14.40	125.0
Texas	N/A	[3] 24.75	N/A
Utah	9.92	12.40	80.0
Vermont	8.00	12.40	64.5
Virginia	6.30	N/A	N/A
Washington	13.92	[3] 17.70	78.6
West Virginia	10.00	16.50	60.6
Wisconsin	16.23	18.10	89.7
Wyoming	16.30	14.40	113.2
Simple Average	12.43	18.56	67.0

N/A : Not available.

[1] Statewide average maximum as reported to HCFA. It is not known which, if any States have different maximums in different parts of the State.

[2] Highest allowable charge anywhere in State.

[3] Maximum payment for general practitioner; value for specialist is unavailable.

[4] Includes Maryland suburbs.

[5] Information available only for part of State.

Source: Congressional Research Service analysis of Medicaid data from U.S. Department of Health and Human Services. Health Care Financing Administration. Analysis of State Medicaid Program Characteristics, 1986. Table 56, August 1987 ***and*** Medicare data from U.S. Department of Health Human Services. Health Care Financing Administration, Medicare Directory of Prevailing Charges. 1984.

Table G–4.—MEDICAID MAXIMUM PAYMENTS AND MEDICARE MAXIMUM ALLOWABLE CHARGES, SPECIALISTS, 1986

	Appendectomy (CPT code 44950)		
	Medicaid [1]	Medicare [2]	Medicaid as percent of Medicare
Alabama	$405.00	$412.80	98.1
Alaska	N/A	N/A	N/A
Arkansas	275.00	412.60	66.7
California	353.68	825.20	42.9
Colorado	280.00	433.20	64.6
Connecticut	[3] 276.00	700.00	39.4
Delaware	390.35	492.70	79.2
District of Columbia	315.00	[4] 515.60	61.1

Table G–4.—MEDICAID MAXIMUM PAYMENTS AND MEDICARE MAXIMUM ALLOWABLE CHARGES, SPECIALISTS, 1986—Continued

	Appendectomy (CPT code 44950)		
	Medicaid [1]	Medicare [2]	Medicaid as percent of Medicare
Florida	197.50	674.60	29.3
Georgia	399.50	600.00	66.6
Hawaii	453.66	660.10	68.7
Idaho	336.40	476.10	70.7
Illinois	270.00	605.00	44.6
Indiana	533.00	515.75	103.3
Iowa	N/A	500.00	N/A
Kansas	268.00	536.20	50.0
Kentucky	401.60	515.75	77.9
Louisiana	411.16	722.00	56.9
Maine	217.50	536.40	40.5
Maryland	202.00	515.70	39.2
Massachusetts	233.00	515.75	45.2
Michigan	271.50	399.00	68.0
Minnesota	520.00	519.90	100.0
Mississippi	295.05	510.00	57.9
Missouri	220.00	567.40	38.8
Montana	342.88	489.90	70.0
Nebraska	453.90	453.90	100.0
Nevada	673.72	[5] 742.70	90.7
New Hampshire	225.00	490.00	45.9
New Jersey	211.00	660.20	32.0
New Mexico	396.15	579.60	68.3
New York	160.00	1,140.20	14.0
North Carolina	378.00	536.40	70.5
North Dakota	449.05	494.80	90.8
Ohio	337.50	515.75	65.4
Oklahoma	500.00	610.00	82.0
Oregon	387.98	577.60	67.2
Pennsylvania	301.50	515.70	58.5
Rhode Island	205.00	515.75	39.7
South Carolina	307.40	440.92	69.7
South Dakota	345.00	455.80	75.7
Tennessee	449.50	536.50	83.8
Texas	N/A	[5] 618.90	N/A
Utah	430.12	N/A	N/A
Vermont	225.00	490.00	45.9
Virginia	236.25	515.60	45.8
Washington	290.23	576.80	50.3
West Virginia	230.00	515.75	44.6
Wisconsin	432.85	663.80	65.2
Wyoming	483.50	464.30	104.2
Average	337.97	557.47	60.6

N/A : Not available.

[1] Statewide average maximum as reported to HCFA. It is not known which, if any, States have different maximums in different parts of the State.

[2] Highest allowable charge anywhere in State.

[3] Maximum payment for general practitioner; value for specialists is unavailable.

[4] Includes Maryland suburbs.

[5] Information available only for part of State.

Source: Congressional Research Service analysis of Medicaid data from U.S. Department of Health and Human Services. Health Care Financing Administration, Analysis of State Medicaid Program Characteristics, 1986. Table 56, August 1987 ***and*** Medicare data from U.S. Department of Health and Human Services. Health Care Financing Administration. Medicare Directory of Prevailing Changes, 1984.

There are a number of limitations to this comparison. First, as noted earlier, Medicaid and Medicare patients may use different types of physicians. Medicaid patients may be more likely to visit pediatricians or obstetricians, while Medicare patients might see cardiologists. Second, the Medicare maximums are set at the 75th percentile of all physicians' charges and may be lower than the customary charges of many physicians. (Physicians who do not accept assignment under Medicare may make up the difference through balance billing.) Third, the Medicare ceilings in use in early 1986 reflect a rate freeze and really represent physicians' charges almost 3 years earlier. Finally, there may be differences in the complexity of the services provided to Medicaid and Medicare patients. This could affect the rate comparison for appendectomies, but not for office visits (the rate cited is for a visit of fixed duration).

Despite these drawbacks, the Medicaid-Medicare comparison does permit some observations. The average ratio of the Medicaid maximum to the Medicare maximum, in the States where this comparison is possible, was .70 for office visits and .63 for appendectomies. The median ratios are closer together: .66 for office visits and .65 for appendectomies. Taken alone, the numbers would suggest that the gap between Medicaid reimbursement and private charges has increased in the years between 1978 and 1986. The gap may be wider if the Medicare maximums were themselves falling behind private physician fees during this period as a result of the rate freeze.

The apparent slippage in Medicaid rates has not, however, been universal. Some States have at least kept pace with Medicare reimbursement. These have tended to be the States that continued to use prevailing charge screens comparable to Medicare's, instead of establishing maximum rates through an arbitrary fee schedule (see table IV-3 for a listing of these States). In prevailing charge States, the average Medicaid/Medicare ratio was .86 for office visits and .81 for appendectomies. The average in States setting maximums by some other method was .60 for office visits and .53 for appendectomies.

States with the highest Medicaid/Medicare ratios were, for office visits, Tennessee, Alaska, Wyoming, and Indiana. For appendectomies, they were Wyoming, Indiana, Minnesota, and Nebraska. The States with the lowest Medicaid/Medicare ratios for office visits were Michigan, New York, Connecticut, and California. For appendectomies, they were New York, Florida, New Jersey, and Missouri. The high-ratio States include some that, on other program measures such as eligibility or coverage policy, may be regarded as having very restrictive Medicaid programs, while the low-ratio States include some that are often classed as having very generous Medicaid programs. This would suggest that decisions on physician reimbursement may be made outside the context of general policies on access to care. One recent analysis argues that some States adopted physician fee schedules in the early 1970's because this was an easy way of obtaining cost savings at a time when States were mandated to pay hospitals and nursing homes on a full reasonable cost basis.[19]

II. HOSPITALS

Virtually all hospitals (other than Federal facilities or hospital units within prisons and other institutions) participate in Medicaid to some extent. Of non-Federal hospitals responding to the 1984 American Hospital Association (AHA) survey, 98 percent treated at least some Medicaid beneficiaries on an inpatient basis during the year. Among those offering outpatient services, only a handful—12 out of 5,606 respondents—had treated no Medicaid patients.[20]

As with physicians, however, a simple classification of facilities as participating or nonparticipating gives no indication of the extent to which hospital services are available to beneficiaries. Hospitals may be presented with some cases to whom they cannot refuse services on financial grounds, such as women in labor or other patients in need of urgent care, and still have an overall policy of refusing nonemergency care to patients with insufficient resources. There are widespread allegations that some private hospitals, especially those operated for profit, tend to deny elective care to Medicaid patients because of inadequate reimbursement levels. In order to examine these allegations, it is necessary to consider relative levels of Medicaid participation, and to take into account factors other than explicit hospital policies that could affect different hospitals' Medicaid caseloads.

A. Hospital Participation Levels

The level of a hospital's participation in Medicaid can be measured in two ways:

- The hospital's share of the total Medicaid patient load. Which hospitals are Medicaid beneficiaries likely to use?
- The Medicaid share of the hospital's total patient load. At which hospitals do Medicaid patients make up a higher proportion of the total patient population?

Table G–5 shows 1984 levels of participation in Medicaid, using both of these measures, for three types of hospitals: public non-Federal, private for-profit, and private nonprofit.

Table G–5.—MEDICAID AND TOTAL HOSPITAL SERVICES, BY HOSPITAL OWNERSHIP, 1984

[In thousands of dollars]

	Medicaid services	Total services	Medicaid as percent of total services	Provider type share of Medicaid services	Provider type share of total services
Inpatient days:					
Public Non-Federal	8,930	47,938	18.6	30.6	19.1
Private For-profit	1,317	20,389	6.5	4.5	8.1
Private Nonprofit	18,955	182,455	10.4	64.9	72.8
Total	29,202	250,782	11.6	100.0	100.0

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[19] Holahan, John F., and Joel W. Cohen. Medicaid: The Tradeoff between Cost Containment and Access to Care. Washington. 1986. p. 61.

[20] Except as noted, information from the AHA survey was compiled by the Congressional Research Service from tape data supplied by AHA.

Table G–5.—MEDICAID AND TOTAL HOSPITAL SERVICES, BY HOSPITAL OWNERSHIP, 1984—Continued

[In thousands of dollars]

	Medicaid services	Total services	Medicaid as percent of total services	Provider type share of Medicaid services	Provider type share of total services
Inpatient discharges:					
Public Non-Federal	926	6,610	14.0	26.4	19.2
Private For-profit	213	3,239	6.6	6.1	9.4
Private Nonprofit	2,362	24,623	9.6	67.5	71.4
Total	3,501	34,472	10.2	100.0	100.0
Outpatient visits:					
Public Non-Federal	7,835	50,846	15.4	29.4	24.3
Private For-profit	563	10,918	5.2	2.1	5.2
Private Nonprofit	18,251	147,860	12.3	68.5	70.5
Total	26,649	209,624	12.7	100.0	100.0

Source: Congressional Research Service analysis of American Hospital Association 1984 Annual Survey of Hospitals data.

For inpatient services, Medicaid beneficiaries are substantially more likely to be treated in public non-Federal hospitals than are other patients, and are only two-thirds as likely to be admitted to private for-profit facilities. They are slightly less likely than other patients to be admitted to private nonprofit hospitals. Still, as is true for the rest of the population, private nonprofit hospitals furnish most of the inpatient care used by Medicaid beneficiaries, nearly two-thirds of the total. The patterns are very similar for outpatient care, except that for-profit facilities provide an even smaller proportion of Medicaid outpatient services than of inpatient services.

A slightly different picture emerges when hospital location is taken into account. Table G–6 shows the 1982 distribution of Medicaid care in public and private facilities in large cities, smaller metropolitan areas, and non-metropolitan areas.[21] The patterns in metropolitan areas generally conform to those observed nationally. In nonmetropolitan areas, however, the distribution of Medicaid patients is virtually identical to the distribution of all patients. That is, ownership has no apparent impact on the extent to which hospitals participate in Medicaid.

Table G–6.—TOTAL HOSPITAL CARE AND CARE TO MEDICAID BENEFICIARIES BY LOCATION AND TYPE OF FACILITY, 1982

	Percent of all care	Percent of Medicaid care	Medicaid as percent of all care
All areas:			
Public	21.6	24.9	10.3
Private	78.4	75.1	8.6
100 largest cities:			
Public	16.8	21.8	14.8
Private	83.2	78.2	10.7

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[21] Note that the figures combine inpatient and outpatient services; the aggregates are therefore different from those shown in the preceding tables.

Table G-6.—TOTAL HOSPITAL CARE AND CARE TO MEDICAID BENEFICIARIES BY LOCATION AND TYPE OF FACILITY, 1982—Continued

	Percent of all care	Percent of Medicaid care	Medicaid as percent of all care
Other metropolitan areas:			
Public	17.7	23.1	10.6
Private	82.3	76.9	7.6
Nonmetropolitan:			
Public	35.1	34.8	7.1
Private	64.9	65.2	7.2

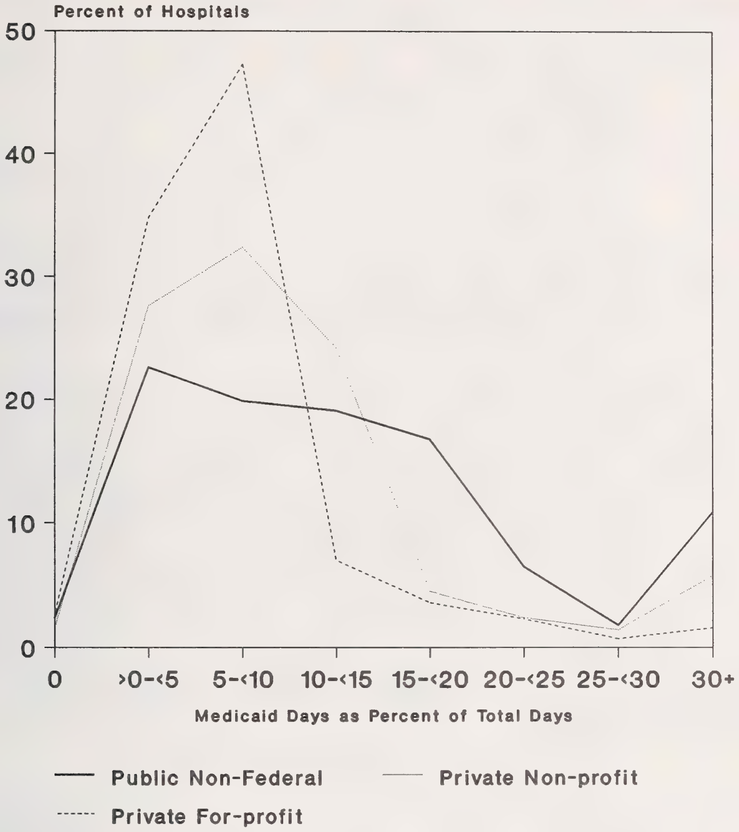
Source: Congressional Research Service analysis of American Hospital Association and Urban Institute data, reproduced in Feder, Judith, Jack Hadley, and Ross M. Mullner. Falling Through the Cracks: Poverty, Insurance Coverage, and Hospital Care for the Poor, 1980 and 1982. Milbank Quarterly, 62:4 (Fall 1984). p. 549

One possible explanation is that, whether public or private, a hospital in a nonmetropolitan area is more likely to serve as the primary source of care for the area it serves. Some people have suggested that, if a hospital is the only provider of care in an area, it will be more likely to accept all kinds of patients, regardless of insurance source or ability to pay. If, on the other hand, there are many hospitals in an area, some may be tempted to act as "free riders," allowing other hospitals to carry the burden. That is, they will feel more able to deny care to some patients if they can assume that other hospitals are available to those patients. This hypothesis assumes, however, that all the hospitals in a metropolitan area are operating in a single market and that Medicaid beneficiaries are equally likely to seek care at any of the facilities. It is possible that, within a metropolitan area, public hospitals are located in areas with high concentrations of Medicaid beneficiaries and are simply more accessible to them.

In any event, classification of hospitals into broad categories for the purpose of analyzing Medicaid participation has the effect of masking substantial variation at the individual facility level. Figure G-1 shows the distribution of hospitals by the percentage of their total inpatient days furnished to Medicaid beneficiaries. In each of the three categories (public, private nonprofit, and private for-profit), a handful of facilities treat a very high proportion of Medicaid patients, while the rest treat relatively few. The pattern is strongest among for-profit facilities. In 85 percent of the for-profits, Medicaid accounts for less than 10 percent of patient days; Medicaid accounts for 20 percent or more of the days in only 5 percent of the for-profit hospitals. Among the public hospitals, 45 percent furnished less than 10 percent of total days to Medicaid beneficiaries. Nearly 20 percent of the public hospitals had Medicaid shares of 20 percent or higher.

Finally, there is evidence that teaching hospitals (those with interns and residents) are likely to provide more care to Medicaid beneficiaries than nonteaching hospitals. Table G-7 gives the results of a study of Medicaid participation by hospitals in large cities in 1980. (It should be noted that the numbers in this table reflect the Medicaid percentage of hospital patient revenues, rather than of hospital services, as in the other tables.) What the figures indicate is that, while teaching status affects participation, it is much less significant than ownership. Public nonteaching facilities

Figure G-1
Inpatient Hospital Services, Medicaid Share of Total Days



Source: Congressional Research Service analysis of 1984 American Hospital Association data.

receive a higher proportion of patient revenues from Medicaid than private teaching facilities. (Again, the data do not take into account the potential impact of location.)

Table G–7.—MEDICAID AS A PERCENTAGE OF GROSS PATIENT REVENUES, FISCAL YEAR 1980

Hospital type	Percent
Public hospitals	17.13
Nonteaching	14.12
Minor teaching	22.42
Major teaching	16.01
Private	8.55
Nonteaching	8.05
Minor teaching	7.98
Major teaching	9.86
All hospitals	12.21

Note: "Minor" and "major" teaching hospitals are generally distinguished by the ratio of interns or residents to patients. The "major" hospitals tend to be medical school teaching facilities or large public medical centers.

Source: Hadley, Jack, Judith Feder, and Ross Mullner. Care to the Poor and Hospitals' Financial Status: Results of a 1980 Survey of Hospitals in Large Cities. Working Paper No. 1444–02. Washington: Urban Institute. May 1983. Cited in Mulstein, Suzanne. The Uninsured and the Financing of Uncompensated Care: Scope, Costs, and Policy Options. Inquiry, 21: 214–29 (Fall 1984). Table 6, p. 223.

One factor which should be considered before drawing any conclusions from these statistics is the possibility that the national data are affected by regional differences in the numbers of persons covered by Medicaid, differences which happen to correspond to regional patterns of hospital ownership. For-profit hospitals have historically been most prevalent in the South and West. States in these regions, especially those in the South, have also tended to have the most restrictive Medicaid eligibility policies. They are, for example, less likely to have medically needy programs. The effect may be that there are proportionately fewer Medicaid beneficiaries in the areas most likely to be served by for-profit facilities. On the other hand, as table G–11 (below) indicates, Medicaid hospital reimbursement levels in these States may be more generous than elsewhere in the country.

B. Explaining Levels of Participation

Broadly speaking, there are two possible ways of explaining a particular hospital's relative level of participation in Medicaid. First, the pool of Medicaid beneficiaries seeking treatment at the hospital might be larger or smaller, depending on circumstances which may or may not be under the hospital's control. Second, the hospital could have explicit policies relating to the acceptance or nonacceptance of Medicaid patients.

1. VARIATIONS IN MEDICAID DEMAND

As was suggested above, some hospitals might have fewer Medicaid patients than others because they were in locations not readily accessible to many Medicaid beneficiaries, or because they did not offer specific kinds of services that Medicaid beneficiaries are likely to require. Within a metropolitan area, for example, a suburban hospital might be less likely than a hospital in a central city to treat many Medicaid patients. A hospital that failed to offer obstetrical care, which is a major source of Medicaid admissions (see below), might also be expected to see fewer Medicaid patients.

Some observers have argued that these differences among hospitals are themselves market-driven. In deciding about location or about the kinds of services to offer, some hospitals might take into account the potential impact of these decisions on the hospitals' volume of private, Medicare, Medicaid and uninsured patients.

On the issue of location, at least, this view may be an oversimplification. Where hospitals are located today is the product of historic decision making over many years. These decisions were economic in the sense that most hospital construction in recent decades has been in areas of population growth, such as the suburbs, and areas with a strong economic base. Less new construction occurred in areas with declining populations, such as the older central cities, and a weaker economic base. One consequence may have been that many new facilities were located in areas with a lower concentration of Medicaid and uninsured patients. To say this is not to say, however, that the insurance status of the local population was a direct factor in the location decisions.[22]

Decisions about the types of services to offer may be more directly driven by current market factors. Some kinds of services are generally less profitable than others, partly but not entirely because they are more likely to attract Medicaid beneficiaries or uninsured patients. These include, not only obstetrical care, but also outpatient and emergency room services.[23] Unlike decisions about location, hospitals' decisions about services can be changed at any time. Recently, for example, hospitals in some areas have closed existing emergency rooms or have dropped out of trauma networks, reportedly because they were losing money on Medicaid and uninsured patients.[24]

One other indirect factor in the extent of a hospital's Medicaid participation does not appear to have been investigated. The volume of Medicaid patients admitted to a particular hospital might be related to the practice patterns of the physicians associated with that hospital. For example, if a hospital's admissions came mainly from affiliated office-based practitioners with very limited Medicaid practices, the hospital's Medicaid volume might be relatively small even in the absence of any direct hospital decision to limit Medicaid volume.

Hospitals that have received Hill-Burton Act construction grants and whose affiliated physicians do not treat Medicaid beneficiaries are required by regulations (42 CFR 124.602(d)(2)) to find other ways of insuring that Medicaid beneficiaries have access to their services. For example, they may require staff physicians to accept Medicaid patients or may contract with outside physicians who do treat Medicaid beneficiaries.

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[22] It is possible that assessment of a hospital's current market plays a more direct role in acquisition, as opposed to construction, decisions. A national proprietary hospital chain considering whether to buy an existing hospital would be expected to consider the hospital's mix of insured and uninsured patients in deciding whether the hospital could be profitable.

[23] Watt, J. Michael, et al. The Effects of Ownership and Multihospital System Membership on Hospital Functional Strategies and Economic Performance. In Institute of Medicine, For-Profit Enterprise in Health Care. Washington. 1986. p. 260–289.

[24] Pinkney, Deborah S. Nation Seeing Breakdown of Trauma Care Networks. American Medical News. May 27, 1988. p. 3–4. Johnston, Brian D. Emergency: Los Angeles Medical Care. Los Angeles Times. May 15, 1988. Pt. 5, p. 1, 6.

2. HOSPITAL ADMISSION POLICIES

Unlike individual practitioners, most hospitals do not have complete discretion over whom they will and will not treat. The decision making is usually shared between the hospital and its attending physicians, who traditionally control admissions. Hospital administrators who wish to limit their Medicaid patient load may vary in the degree of direct control they are able to exercise over physician admitting decisions. Because open interference in these decisions may be taken as interference with physician prerogatives, some hospitals might seek to influence the flow of admissions in more subtle ways.

One recent study has attempted to investigate this possibility. Schlesinger et al., drawing on a 1984 American Medical Association survey of physicians, explored the physicians' own perceptions of the extent to which the principal hospital they used attempted to discourage the admission of Medicaid and uninsured patients. Table G–8 shows the results, by type of hospital. (It should be noted that the percentages are of responding physicians affiliated with the type of hospital in question, not percentages of hospitals.) The pattern of reported "discouragement" conforms roughly to the pattern of actual Medicaid participation levels, with physicians at for-profit facilities considerably more likely to report that their institutions discouraged Medicaid patients.[25]

Table G–8.—PERCENT OF PHYSICIANS REPORTING THAT THEIR PRIMARY HOSPITAL DISCOURAGED ADMISSION OF MEDICAID PATIENTS

Hospital type	Percent
Independent hospitals:	
For-profit	15
Private nonprofit	5
Public	3
Multihospital systems:	
For-profit	16
Private nonprofit	6
Public	3

Source: Schlesinger, Mark, et al. The Privatization of Health Care and Physicians' Perceptions of Access to Hospital Services. Milbank quarterly, 65:1 (1987). p.25–58. Table 1, p. 33.

The extent to which some institutions may be deliberately refusing Medicaid admissions, rather than merely discouraging them, is less clear. Several studies have explored the issue of inappropriate hospital transfers: the allegation that some facilities refuse to treat severely ill Medicaid patients, or transfer them as rapidly as possible to other hospitals. The largest systematic investigations of this issue are two studies of patients who had been transferred from other hospitals to the emergency rooms of public hospitals in Alameda County, California, and Cook County, Illinois, in 1981 and 1983–84, respectively.[26] In 87 percent of the Cook County cases, the hospital requesting the transfer explicitly gave the patient's lack of adequate insurance coverage as the reason for transfer; no comparable figure is available for the Alameda County study. (The Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99–272, prohibits hospitals participating in Medicare from transferring medically unstable patients.)

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[25] Schlesinger, Mark, et al. The Privatization of Health Care and Physicians' Perceptions of Access to Hospital Services. Milbank Quarterly, 65:1 (1987), p. 25–58.

[26] Himmelstein, David U., et al. Patient Transfers: Medical Practice as Social Triage. American Journal of Public Health, 74:5 (May 1984), p. 494–7. Schiff, Robert L., et al. Transfers to a Public Hospital: A Prospective Study of 467 Patients. New England Journal of Medicine, 314:9 (Feb. 27, 1986), p. 552–57.

Table G–9 shows the breakdown of the transferred patients by insurance status. Different patterns appear in the two studies. A higher proportion of the transferred patients in California were covered by Medicaid, 21 percent as compared to 6 percent in Illinois. The comparison is complicated by the fact that, in Illinois, 40 percent of the transferred patients were covered by General Assistance, a State funded cash and medical assistance program distinct from the federally funded Medicaid program.[27] It is not known whether patients in California comparable to the Illinois General Assistance recipients were uninsured, or whether they were covered by State or locally funded programs and categorized as "Medicaid." This classification problem may explain some of the difference in the results of the two studies. The remaining difference may be attributable to differences in Medicaid reimbursement or coverage policies in the two States or may reflect differences in the nature or practices of the surrounding hospitals from which patients were transferred. Taken together, the two studies suggest that some hospitals might exclude Medicaid patients but also indicate that hospital policies may vary according to local circumstances.

Table G–9.—PATIENT TRANSFERS TO PUBLIC HOSPITAL EMERGENCY ROOMS BY PATIENT INSURANCE STATUS

Insurance status	Percent of patients	
	Highland General, California 1981 (n=458)	Cook County Hospital, Illinois 1983–84 (n=467)
No Insurance	63	46
Medicaid	21	[1] 6
Medicare	13	3
General Assistance [2]	N/A	40
Private Insurance	3	4
Miscellaneous [2]	N/A	1

N/A : Not applicable.

[1] Persons reported as insured by the Illinois Department of Public Aid and not falling into the State-funded General Assistance category. May include some persons covered by programs other than Medicaid.

[2] Categories used only in Cook County study.

Source: Himmelstein, David U., et al. Patient Transfers: Medical Practice as Social Triage. American Journal of Public Health, 74:5 (May 1984), p. 494– 7. [Highland General] ***and*** Schiff, Robert L., et al. Transfers to a Public Hospital: A Prospective Study of 467 Patients. New England ***Journal of Medicine,*** 314:9 (Feb. 27, 1986), p. 552–57. [Cook County]

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[27] State general assistance or general relief programs typically cover low-income persons who do not meet the categorical criteria for cash assistance or Medicaid eligibility. That is, the beneficiaries are not aged, blind, disabled (by Federal standards), or members of families with children.

The investigators noted that, during the 1983–84 study period, the General Assistance program in Illinois paid a flat $500 per hospital admission, regardless of the length of stay or services provided. Illinois Medicaid was paying an average of $274 per day in fiscal year 1983. Different reimbursement policies of two low-income medical assistance programs within a single State apparently had an impact on providers' willingness to accept the programs' beneficiaries.

A second potentially relevant indicator of hospital practices for which national, rather than local, data are available is length of stay: the number of days of care provided to each patient admitted. Severity of illness is not necessarily the key determinant of how long patients stay in a particular hospital; other factors, such as physician practice patterns, may be equally important. Still, if one class of facilities routinely excluded sicker Medicaid beneficiaries while admitting the less severely ill, this might be reflected in length of stay.

Table G–10 shows length of stay by facility ownership, again drawn from the 1984 AHA survey. Overall, Medicaid patients stayed in the hospital longer than others. This general tendency may be partially attributable to non-medical factors. For example, Medicaid patients may remain in the hospital longer than they need to because of difficulties in arranging home care or finding a nursing home placement (see the next section for a discussion of the latter problem).

Table G–10.—AVERAGE HOSPITAL STAY IN DAYS, MEDICAID AND TOTAL POPULATION, BY HOSPITAL OWNERSHIP, 1984

	Average Medicaid stay	Overall average stay	Ratio of Medicaid average to overall average
Public Non-Federal	9.6	7.3	1.3
Private For-profit	6.2	6.3	1.0
Private Nonprofit	8.0	7.4	1.1
Total	8.3	7.3	1.1

Source: Congressional Research Service analysis of American Hospital Association 1984 Annual Survey of Hospital data.

The average length of stay for Medicaid patients in for-profit facilities is significantly shorter than in other hospitals. While this might appear to support allegations that these facilities are refusing the sicker Medicaid patients, the average Medicaid length of stay is almost identical to the average for all patients in for-profit hospitals. This would suggest that the for-profits may be accepting less severe cases (or transferring difficult patients to other facilities) regardless of payment source.[28]

C. Impact of Medicaid Policies

The Schlesinger study cited earlier, detailing the extent to which hospitals discouraged physicians from admitting Medicaid patients, found some correlation between State Medicaid policies and hospitals' perceived willingness to accept Medicaid beneficiaries. (Other factors, such as ownership, were much more important.) Hospitals in States that had shifted from full cost reimbursement to prospective payment for inpatient services were more likely to discourage Medicaid admissions, as were hospitals in States that had established prior authorization requirements for inpatient care.[29] Hospitals in these States were also more likely to discourage admission of uninsured patients, a phenomenon to be discussed further at the end of this section.

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[28] This view was confirmed in Bays, Carson. Case Mix Differences between Nonprofit and For-profit Hospitals. Inquiry, 14:1 (March 1977), p. 17–21. More recent evidence that for-profit hospitals generally treat less severely ill patients may be found in Watt, J. Michael, et al., op.cit.

[29] Schlesinger et al., op.cit., p. 41.

1. MEDICAID HOSPITAL REIMBURSEMENT

Nationally, the AHA survey data indicate that Medicaid beneficiaries used 11.6 percent of the total days of inpatient care provided by hospitals in 1984, and 12.7 percent of the outpatient visits. In the same year, HCFA's Office of the Actuary estimates that Medicaid reimbursement accounted for only 8.8 percent of national expenditures for hospital care.

Table G–11 compares by State the average fiscal year 1985 Medicaid payment per day of inpatient care with the average expense per day reported by community hospitals in the AHA annual survey for calendar 1985. (States failing to report average Medicaid payments to HCFA are omitted from the table.) In 32 States, the average Medicaid payment was below the average hospital cost per day, while in 10 States the average Medicaid payment was above the average cost. In some States where the Medicaid payment was below average cost, the difference was small enough to be accounted for by the difference in base periods for the AHA and Medicaid data.[30] In others, the difference was more dramatic. However, at least two factors potentially complicate this comparison.

Table G–11.—AVERAGE MEDICAID INPATIENT PER DIEM PAYMENT, FISCAL YEAR 1985 AND AVERAGE PER DIEM COST FOR ALL COMMUNITY HOSPITALS, 1985

	Medicaid per diem payment, fiscal year 1985	Per diem expense All Patients CY 1985	Medicaid payment as percent of expense
Alabama	$332	$389	85.3
Arkansas	395	381	103.7
Colorado	348	486	71.6
Connecticut	429	502	85.5
District of Columbia	533	612	87.1
Florida	373	494	75.5
Georgia	483	386	125.1
Idaho	472	373	126.5
Illinois	413	498	82.9
Indiana	313	446	70.2
Iowa	248	359	69.1
Kansas	306	401	76.3
Kentucky	359	367	97.8
Louisiana	373	475	78.5
Maine	247	394	62.7
Maryland	445	443	100.5
Massachusetts	389	500	77.8
Michigan	455	507	89.7
Minnesota	311	369	84.3
Mississippi	380	319	119.1

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[30] The AHA data are for a year ending 3 months later than the year used for the Medicaid rates. In addition, the Medicaid figures reflect claims actually paid during fiscal year 1985, while the AHA data represent costs for services rendered during the reporting period. When payment delays are taken into account, the AHA figures may represent about 6 months' inflation over the costs during the Medicaid base year.

Table G–11.—AVERAGE MEDICAID INPATIENT PER DIEM PAYMENT, FISCAL YEAR 1985 AND AVERAGE PER DIEM COST FOR ALL COMMUNITY HOSPITALS, 1985—Continued

	Medicaid per diem payment, fiscal year 1985	Per diem expense All Patients CY 1985	Medicaid payment as percent of expense
Missouri	314	457	68.7
Montana	393	312	126.0
Nebraska	160	347	46.1
Nevada	360	677	53.2
New Mexico	486	501	97.0
North Carolina	289	356	81.2
Ohio	466	493	94.5
Oklahoma	308	455	67.7
Oregon	343	549	62.5
Pennsylvania	280	468	59.8
Rhode Island	335	447	74.9
South Carolina	429	358	119.8
South Dakota	270	282	95.7
Tennessee	502	397	126.4
Texas	415	461	90.0
Utah	380	556	68.3
Vermont	308	343	89.8
Virginia	379	399	95.0
Washington	351	546	64.3
West Virginia	407	399	102.0
Wisconsin	329	392	83.9
Wyoming	402	367	109.5

Source: U.S. Department of Health and Human Services. Health Care Financing Administration. Analysis of State Medicaid Program Characteristics, 1986. Table 54. August 1987 ***and*** American Hospital Association. Hospital Statistics, 1986 edition. 1986.

First, as has already been shown, some facilities serve a larger proportion of Medicaid patients than others. These hospitals may have higher or lower operating costs than the statewide average. The ordinary perception is that public hospitals are the most expensive and private for-profit hospitals the least expensive. In fact the reverse is true. AHA data from 1985 indicate that on a national basis for-profit hospitals had the highest average cost per day, $500.48. Public hospitals were the least costly, at $432.84 per day, while private nonprofits were in between, averaging $462.69 per inpatient day.[31] That Medicaid patients are disproportionately seen in public hospitals might suggest that their costs should be below average. The reverse might be true to the extent that Medicaid beneficiaries are concentrated in the center cities of urban areas; hospitals in the center cities would tend to be more costly than the Statewide averages. In addition, the higher use of teaching hospitals by Medicaid beneficiaries would tend to increase costs.

Second, there is the problem of case mix: the possibility that the illnesses or conditions for which Medicaid beneficiaries are treated in hospitals are different from those of other patients and require more or less costly care. It is not sufficient to say that Medicaid is paying a particular hospital more or less per day than some other insurer, because a day in a maternity ward is unlikely to cost the same as a day in an intensive care unit. A study of 1982 Medicaid data for three States found that pregnancy accounted for 7.8 percent of Medicaid hospital expenditures in New York, 13.1 percent in California, and 17.6 percent in Michigan.[32] For all patients nationally, Medicaid and non-Medicaid, only 3.5 percent of hospital expenditures were for admissions in an "Other" category that includes pregnancy and several other diagnoses. The study also found that, if pregnancies were omitted, the distribution of diagnoses for Medicaid patients resembled that for the population at large. However, the comparison involved grouping patients into just 19 major diagnostic categories. There may have been differences in severity within each group.

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[31] American Hospital Association. Hospital Statistics, 1986 edition. Chicago. 1986. p. 5.

Another study used diagnosis related groups (DRGs), a more exact measure of relative severity, to classify Medicare, Medicaid, and Blue Cross cases in 28 New York State hospitals in 1978.[33] The study found that Medicaid had the least costly case mix; that is, the conditions for which Medicaid beneficiaries were admitted were likely to require fewer resources than were required for Medicare or Blue Cross patients. However, the study also found that, within a given DRG, Medicaid patients tended to cost more than Blue Cross patients.

In summary, a fully satisfactory comparison of Medicaid hospital reimbursement and hospital costs would require more information than is presently available about what kinds of conditions Medicaid patients are treated for, what services they use, and where they get those services.

2. OTHER MEDICAID POLICIES

A second area of Medicaid policy that potentially affects hospital participation is service limitations. As chapter III indicates, a number of States have fixed limits on the number of inpatient days they will cover. States may also limit coverage of, or offer reduced reimbursement for, "administrative days," the time spent in a hospital by a patient who no longer requires hospital services but who cannot be placed elsewhere. Many States have adopted systems of retrospective utilization review. Payment may be denied if a beneficiary's inpatient stay, or some part of it, is found to be medically unnecessary. All of these practices place hospitals at some risk of furnishing care for which payment may later be unavailable and may have the effect of discouraging participation. Limits on covered days may have an especially strong effect on hospitals' willingness to accept severely ill patients.

Other State policies are aimed directly at deterring avoidable hospital admissions. These include requirements for prior authorization of elective admissions, second surgical opinion programs, or policies intended to encourage the performance of certain kinds of surgery on an outpatient basis. (See chapter III for a discussion of these policies.) Although comparable policies have increasingly been adopted by other insurers, Medicaid programs were among the first to impose these sorts of controls. While it would seem that policies of this kind would affect all hospitals equally, it is conceivable that some hospitals find them administratively cumbersome or that they have a disproportionate impact on the types of services offered at specific facilities.

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[32] Pine, Penelope L., Embry M. Howell, and William Buczko. Hospital Utilization and Expenditures for Medicaid Enrollees by Major Diagnosis Group. Health Care Financing Review, 9:1 (Fall 1987), p. 91–96.

[33] Martin, Suzanne G., Alexander P. Frick, and Michael Schwartz. An Analysis of Hospital Case Mix, Cost, and Payment Differences for Medicare, Medicaid, and Blue Cross Plan Patients Using DRGs. Inquiry 21: 369–379 (Winter 1984). DRGs involve a much larger number of diagnostic categories (467 at the time of the study) and are a more precise measure of relative severity than the major diagnostic categories, although there are still concerns about variations in severity within some DRGs.

D. Medicaid and Uncompensated Care

There is a strong link between the extent of a hospital's participation in Medicaid and the extent to which it furnishes "uncompensated care," care to persons who are unable to or fail to pay their own bills and who lack adequate insurance coverage. One study found that, at hospitals where charity care and uncollectible "bad debt" amounted to less than 2 percent of total charges, Medicaid accounted for 7.4 percent of gross patient revenues. On the other hand, in facilities where charity care and bad debt amounted to 10 percent or more of total charges, Medicaid provided an average of 15.7 percent of total revenues.[34]

The high correlation between a hospital's Medicaid volume and the amount of uncompensated care it furnishes is not surprising. If, for example, a hospital draws its patients from a low-income area, it is likely to see large numbers of both Medicaid and uninsured patients. The same would be true if the hospital had a general policy of accepting patients regardless of payment source.

However, the Schlesinger study cited earlier found that hospitals did not always have uniform policies on the treatment of Medicaid and uninsured patients. Hospitals of all types were about three times more likely to discourage admission of uninsured patients than of Medicaid patients. A hospital may have an incentive to accept Medicaid patients even when Medicaid reimbursement is below the hospital's usual charges. In a period of declining hospital occupancy rates, even a reduced Medicaid payment may be preferable to leaving a bed empty.[35] Clearly no such incentive exists for the admission of patients with no coverage at all. It might be expected then, that some hospitals would have a high share of Medicaid patients and a low share of the uninsured.

On the other hand, it may be possible that a policy of limiting the number of uninsured patients would have an indirect effect on the extent of a hospital's Medicaid participation. The distinction between Medicaid and uninsured patients is not an absolute one. In States with medically needy programs, beneficiaries may qualify for Medicaid by "spending down," incurring medical bills that reduce their income to the State's medically needy standard. This means that persons entering a hospital without any insurance coverage may become eligible for Medicaid by the end of their stay.

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[34] Sulvetta, Margaret B., and Katherine Swartz. The Uninsured and Uncompensated Care. Washington. 1986. p. 35.

[35] A hospital has fixed costs, such as administration and debt service, that must be met regardless of the number of patients being treated, and additional variable costs for each patient. If Medicaid covers the full variable cost for a bed that would otherwise be empty, and makes at least some contribution to the fixed costs, the hospital is better off than if it had left the bed vacant.

Payments for spend-down beneficiaries may constitute a significant portion of some States' total Medicaid hospital expenditures. In fiscal year 1986, medically needy beneficiaries made up 17.1 percent of all Medicaid beneficiaries under age 65 and accounted for 21.0 percent of total Medicaid inpatient costs for all beneficiaries under age 65 (the medically needy over age 65 are more likely to qualify through nursing home costs). If a hospital in a State with a medically needy program excludes uninsured patients, it is also indirectly limiting its Medicaid reimbursement. This may account for some of the correlation between uninsured and Medicaid caseloads.

Still, it is clear that some hospitals are treating a high share of both Medicaid and uninsured patients. The financial losses resulting from uncompensated care may be compounded if the hospital's Medicaid reimbursement is below the hospital's actual costs for treating Medicaid patients.[36] Moreover, hospitals often rely on collections from patients with insurance to help cover the costs for the uninsured. Even when a Medicaid program pays the full cost for its own beneficiaries, it may not make a proportional contribution to the hospital's costs for the uninsured.

Before 1981, when Medicaid programs followed Medicare cost reimbursement principles, they were generally prohibited from reimbursing costs related to uncompensated care or bad debt. Instead, Medicaid followed a policy of covering only the costs attributable to its own beneficiaries. Although many States have now shifted to prospective payment systems, their rates may still not be high enough to help subsidize uncompensated care. This may be especially true when the rates under prospective systems are based on historic Medicaid cost data.

Congress has mandated that Medicaid reimbursement systems take into account the needs of "disproportionate share" hospitals, those treating a large number of low income patients. As noted in chapter IV, this mandate was strengthened by the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203). States must now comply with explicit standards relating to the designation of disproportionate share hospitals and the amount of additional reimbursement these facilities must receive.

III. NURSING HOMES

Medicaid is the major payer for nursing home services and has been a critical factor in the growth of the industry.[37] Policy discussion has often been dominated by a concern that nursing home services were consuming too much of the Medicaid dollar, and that further demand for these services by an aging population would make it increasingly difficult to meet other possible program goals, such as improving care for families with children.

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[36] Hospitals in this situation may find themselves, possibly because of location, unable to modify the situation. One study found that, while "financially stressed" hospitals tended to reduce their Medicaid participation, they were still treating more Medicaid patients than hospitals in better financial condition. Feder, Judith, Jack Hadley, and Ross M. Mullner. Falling through the Cracks: Poverty, Insurance Coverage, and Hospitals' Care to the Poor, 1980 and 1982. In United Hospital Fund of New York. Hospitals and the Uninsured Poor: Measuring and Paying for Uncompensated Care. New York. 1985. p. 3-30.

[37] In the 8 year period following the enactment of Medicare and Medicaid, 1965-73, the number of nursing home beds grew from 460,000 to 1,1000,000, a 140 percent increase. Hawes, Catherine, and Charles D. Phillips. The Changing Structure of the Nursing Home Industry and the Impact of Ownership on quality, Cost, and Access. In: For-Profit Enterprise in Health Care, Institute of Medicine, National Academy of Sciences. Washington 1986. p. 492-541.

At the same time, however, there is evidence that, at least in some States, Medicaid beneficiaries who need nursing home services are difficult to place. In a survey of States conducted for the Congressional Research Service by the National Governors' Association, Medicaid administrators were asked whether beneficiaries awaiting discharge from hospitals had difficulty finding an available nursing home bed. Of 38 States responding, 28 reported at least some difficulties. In 10 of these States, the problems were confined to "heavy care" patients, those requiring more intensive services. In 4 others, there were problems only for patients in specific geographic areas, usually cities as opposed to rural areas. The remaining 14 States reported general, statewide barriers to access for Medicaid patients, although the placement difficulties were most acute for heavy care patients.[38]

The following discussion reviews recent trends in Medicaid nursing home utilization and summarizes the evidence on two related issues: the total supply of nursing home beds and the relative competitiveness of Medicaid nursing home reimbursement. The section concludes with a review of alleged discriminatory practices in nursing homes and of some of the solutions proposed or enacted at the Federal and State levels.

A. TRENDS IN MEDICAID NURSING HOME UTILIZATION AND COST

The following observations are drawn from analysis of data from several different sources, including Medicaid data, estimates by HCFA's Office of the Actuary, and data from national surveys of nursing homes. Except as noted, the data exclude services in ICFs/MR.

1. MEDICAID'S SHARE OF NATIONAL NURSING HOME EXPENDITURES HAS BEEN DROPPING

As table G–12 indicates, national spending on nursing home services nearly quintupled in the first 10 years after the start of the Medicaid program; Medicaid spending accounted for 60 percent of this growth. By 1968, the program's third year of operation, Medicaid already covered a third of total nursing home expenditures. After the Social Security Amendments of 1972 (Public Law 92–603), which permitted State Medicaid plans to cover ICF and ICF/MR services as well as SNF, Medicaid's share of total expenditures rose even higher, reaching a peak of 48.6 percent in 1979. In the 1980's, however, the Medicaid share has gradually dropped, to a low of 41.4 percent in 1986.

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[38] U.S. Congress. Congressional Research Service. Medicaid Eligibility for the Elderly in Need of Long Term Care. Edward Neuschler, with the assistance of Claire Gill. [National Governors' Association] CRS Report No. 87-986-EPW. Washington. 1987. p. 144–151.

Table G–12.—COMPARISON OF MEDICARE AND MEDICAID SPENDING ON NURSING HOME CARE

Year	Total	Medicare spending	Percent of total	Medicaid spending	Percent of total
1965	$2,072	$0	0.0	$0	0.0
1966	2,356	27	1.1	488	20.7
1967	2,776	210	7.6	908	32.7
1968	3,380	396	11.7	1,137	33.6
1969	3,805	326	8.6	1,234	32.4
1970	4,697	265	5.6	1,422	30.3
1971	5,635	182	3.2	1,926	34.2
1972	6,513	172	2.6	2,571	39.5
1973	7,182	192	2.7	3,080	42.9
1974	8,507	247	2.9	3,902	45.9
1975	10,058	290	2.9	4,822	47.9
1976	11,319	327	2.9	5,352	47.3
1977	13,043	362	2.8	6,166	47.3
1978	15,093	347	2.3	7,137	47.3
1979	17,406	368	2.1	8,463	48.6
1980	20,375	396	1.9	9,778	48.0
1981	23,865	439	1.8	11,250	47.1
1982	26,730	469	1.8	12,341	46.2
1983	29,374	522	1.8	13,049	44.4
1984	31,748	544	1.7	13,729	43.2
1985	34,968	595	1.7	14,837	42.4
1986	38,146	613	1.6	15,803	41.4

Note: All dollar figures are in millions. Nursing home expenditures includes spending for skilled nursing facilities (SNFs), intermediate care facilities (ICF) and intermediate care facilities for the mentally retarded (ICF–MR).
Source: Office of the Actuary, Office of National Cost Estimates, HCFA.

Both the totals and the Medicaid figures in table G–12 include expenditures for ICF/MR services. Medicaid currently accounts for three-quarters of ICF/MR expenditures (see appendix D). In addition, ICF/MR spending has accounted for a steadily greater share of total Medicaid nursing home costs, rising from 8 percent in 1975 to 29 percent in 1986. Direct correction for this factor is not possible, because table G–12 (based on HCFA Office of the Actuary estimates) gives calendar year data, while information on ICF/MR costs is available only for fiscal years. However, if ICF/MR expenditures could be discounted, the reduction in Medicaid's share of ordinary nursing home expenditures during the 1980's would be even greater than shown in the table.

The decline in Medicaid's role as a payer for nursing home services may be partially attributable to cost control measures, such as changes in reimbursement methodology. But other data suggest an alternative explanation: that there has been a shift in the distribution of the Medicaid nursing home population from skilled nursing facilities (SNFs) to less costly intermediate care facilities (ICFs).[39]

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[39] Medicaid law currently requires that average State payments to ICFs be lower than average payments to SNFs. As noted in Chapter V, this requirement will cease to apply when the legal distinction between SNFs and ICFs is eliminated in October 1990.

2. THE MEDICAID NURSING HOME POPULATION HAS BEEN RISING FASTER THAN THE TOTAL NURSING HOME POPULATION. HOWEVER, THIS IS TRUE ONLY IN ICFS

The main source of information about the nursing home industry during this period is the National Nursing Home Survey (NNHS) conducted by the National Center for Health Statistics in 1977 and again in 1985. Table G–13 compares the findings of the two surveys, which project national utilization from a sample of facilities and residents.

Table G–13.—MEDICAID AND TOTAL CURRENT ICF AND SNF RESIDENTS, ONE DAY COUNT, 1977 AND 1985

	1977	1985	Percent change
Medicaid current residents:			
Skilled nursing facility	260,700	263,000	0.9
Intermediate care facility	362,600	488,300	34.7
Total	623,300	751,300	20.5
Total current residents	1,303,100	1,491,400	14.5
Medicaid percentage	47.8	50.4	5.3

Note: Some residents may have more than one source of payment for nursing home care at the time of interview. Residents in this table are classified on the basis of the primary source of payment.

Source: National Center for Health Statistics. The National Nursing Home Survey: 1977 Summary for the United States. Vital and Health Statistics: Series 13, Data from the National Health Survey. No. 43. DHEW Pub. No. (PHS) 79–2794. July 1979. Table 41. ***and*** Esther Hing, National Center for Health Statistics, personal communication.

The total count of current residents (that is, patients in each facility on the night before the particular day it was surveyed) increased by 14.5 percent in the 1977–85 period, from 1,303,100 to 1,491,400. The count of residents for whom Medicaid was listed as the primary payer went from 623,300 in 1977 to 751,300 in 1985, an increase of 20.5 percent.[40] Medicaid's share of the total resident count rose from 47.8 percent to 50.4 percent. Virtually all of the increase, however, has been among patients in ICFs. In SNFs, the count of Medicaid residents went almost unchanged from 1977 to 1985.

3. MANY OF THE CURRENT MEDICAID NURSING HOME RESIDENTS ENTERED THE HOME WITH SOME OTHER SOURCE OF PAYMENT. THIS IS ESPECIALLY TRUE FOR THE OLDEST RESIDENTS

Table G–14 shows, for nursing home residents receiving Medicaid benefits at the time of the 1985 Nursing Home Survey, the proportion receiving Medicaid at the time they were originally admitted to the facility.[41] Of the Medicaid SNF residents, 22.4 percent entered the facility with some other source of payment: Medicare, their own funds, or other third party coverage. Almost the same proportion of Medicaid ICF residents, 20.1 percent, had a different source of payment at the time of admission. (Comparable data are not available for 1977.)

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[40] The count of residents for whom Medicaid is the primary payer is not equivalent to a count of residents on whose behalf Medicaid issued any payment at all. Many Medicaid nursing home residents are contributing to the cost of their own care. Medicaid would be counted as the primary payer only for a month in which Medicaid payment exceeded the patient contribution. This factor, which leads to an understatement of the number of residents receiving Medicaid benefits, could be corrected for in the 1985 data, but not in the 1977 data. For the purpose of comparison, both figures have been left uncorrected.

[41] The resident counts in this table differ from those in Table G–13 in two respects. First, only residents who had been in the home for more than 1 month are included. Second, residents are counted as receiving Medicaid if Medicaid issued any payment at all on their behalf during the month in question, regardless of whether Medicaid was the *primary* source of payment during the month.

Table G–14.—CURRENT NURSING HOME RESIDENTS, BY PAYMENT SOURCE AT ADMISSION AND AT TIME OF INTERVIEW, 1985

Payment source at admission	Payment source at time of interview			
	Medicaid SNF	Medicaid ICF	Other	Total
Number of residents:				
Medicaid SNF	190,189	22,653	2,824	215,666
Medicaid ICF	13,376	382,216	5,979	401,571
Other	58,598	101,938	603,849	764,385
Total	262,163	506,807	612,652	1,381,622
Percent:				
Medicaid SNF	72.5	4.5	0.5	15.6
Medicaid ICF	5.1	75.4	1.0	29.1
Other	22.4	20.1	98.6	55.3
Total	100.0	100.0	100.0	100.0

Note: Analysis limited to nursing home residents with more than a 1 month stay in the nursing home. Some residents may rely on more than one source of payment for their stay. Residents in this table are classified on the basis of receipt of payment.

Source: Congressional Research Service analysis of 1985 National Nursing Home Survey data.

The proportion of residents who received Medicaid benefits at the time of admission drops with the current age of the resident. As table G–15 shows, among all residents aged 65–74, 45.4 percent used Medicaid as their primary source of payment at the time of admission. Of residents aged 85 and older, only 39.4 percent were admitted with Medicaid as their primary payment source. Overall, patients who had originally entered with Medicaid were, at the time of the 1985 survey, somewhat younger than patients who had originally entered with some other payment source. It should be emphasized that this does not mean that *current* Medicaid residents are younger than current non-Medicaid residents.

Table G–15.—NURSING HOME RESIDENTS (AGE 65 AND OVER) BY CURRENT AGE AND PRIMARY SOURCE OF PAYMENT AT ADMISSION, 1985

Age	Medicaid primary payer	Percent of age group with Medicaid	Other primary payer	Percent of age group with other payer	Total	Percent
65 to 74	96,293	45.4	115,807	54.6	212,100	100
75 to 84	197,492	38.8	311,508	61.2	509,000	100
85 and over	234,312	39.4	360,388	60.6	594,700	100
	528,097	40.1	787,703	59.9	1,315,800	100

Source: Congressional Research Service analysis of data from National Center for Health Statistics. Esther Hing, Use of Nursing Homes by the Elderly, Preliminary Data from the 1985 National Nursing Home Survey. Advance Data from Vital and Health Statistics, v. 135, DHHS Pub. no. (PHS) 87–1250. May 14, 1987.

The significance of this difference is unclear. There is a high correlation between nursing home residents' age and the degree of their functional impairment. The 1985 survey shows that, as would be expected, older residents were more likely to require assistance with activities of daily living and to suffer from disorientation or dementia. That residents with Medicaid benefits at the time of admission were younger than those who had entered with some other source of payment could suggest that they were also less likely to require intensive services. This is uncertain, however, and could be confirmed only if it were possible to compare age and disability at the time of admission, rather than at the time the survey was conducted.

4. GROWTH IN THE MEDICAID NURSING HOME POPULATION IS APPARENTLY ATTRIBUTABLE TO LONGER STAYS FOR EACH BENEFICIARY SERVED, RATHER THAN TO AN INCREASE IN THE NUMBER OF BENEFICIARIES SERVED

Figures reported by States to HCFA allow a comparison between the total number of Medicaid beneficiaries served by nursing homes over the course of an entire year with the current resident count, representing beneficiaries served on a single day of that year. Table G–16 shows that the total number of Medicaid beneficiaries receiving SNF services dropped significantly between fiscal year 1977 and fiscal year 1985. As noted earlier, the one day count of Medicaid SNF residents in calendar 1977 and 1985 remained stable. The count of beneficiaries receiving ICF services rose somewhat, but at less than half the rate of the resident count.

Table G–16.—MEDICAID BENEFICIARIES RECEIVING NURSING HOME SERVICES, FISCAL YEARS 1977 AND 1985

Medicaid beneficiaries served (full fiscal year count)	1977	1985	Percent change
Skilled nursing facility	640,896	546,627	−14.7
Intermediate care facility	861,071	974,946	13.2
Total	1,501,967	1,521,573	1.3

Source: HCFA–2082 forms.

What these figures suggest is that most of the growth in the Medicaid resident counts is attributable to lower turnover; that is, to an increase in the average length of stay for each beneficiary served. Overall, the number of persons admitted to nursing homes as Medicaid beneficiaries, or converting to Medicaid after admission, rose 1.3 percent between fiscal year 1977 and fiscal year 1985, while the Medicaid current resident count rose 20.5 percent. If the one day current resident counts are more or less representative of utilization throughout the year, each beneficiary remained in the home about 19 percent longer in 1985 than in 1977.[42]

B. NURSING HOME BED SUPPLY

The National Nursing Home Survey found that the supply of nursing home beds rose 15.8 percent between 1977 and 1985. The

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[42] Because the data are drawn from two different sources, State reports to HCFA and nursing home responses to the NNHS, it is conceivable that some of the apparent increase in length of stay is attributable to changes in reporting practices or accuracy. Still, the hypothesis that length of stay has increased for Medicaid beneficiaries conforms to a general 1985 NNHS finding that discharges, regardless of payment source, have increased less (9.5 percent) between 1977 and 1985 than the count of current residents (14.5 percent).

U.S. population over age 65 rose by 21.4 percent in the same period. As a result, the supply of nursing home beds per 1000 population aged 65 and over dropped from 59.7 in 1977 to 56.9 in 1985. At the same time occupancy rates have been rising, from an average of 89.0 in 1977 to an average of 91.6 in 1985.

The slowdown in new nursing home construction, in a period during which the population was aging and the demand for nursing home services was rising, was largely the result of State planning processes established by section 1122 of the Social Security Act and by the National Health Planning and Resources Development Act in 1974. In most States, anyone proposing to build a new nursing home or increase the capacity of an existing one had to obtain a certificate of need from the State planning agency. In States that entered into a section 1122 agreement with the Secretary, a provider that failed to obtain a certificate of need before construction or expansion could be ineligible for Medicare and Medicaid reimbursement for the new beds. The Health Planning Act was repealed in 1986, and the Secretary has since terminated all section 1122 agreements. While the planning processes existed, however, States were able to control the supply of nursing home beds.

States were concerned about the explosive growth in nursing home utilization in the late 1960's and early 1970's, and believed that the demand was such that this growth would continue as long as there were new beds to be filled. As a result States deliberately constrained the supply of new beds. Some States established moratoriums on new construction, while others allowed only very limited growth. In at least some States, the certificate of need process was explicitly seen as a Medicaid cost containment measure; the determination of need might be related to the number of nursing home patients the State was prepared to cover, rather than to the number of persons requiring care.[43]

Table G–17.—NURSING HOME BED SUPPLY BY FACILITY TYPE, 1977 AND 1985

Certification Type	Number of Beds		Percent change
	1977	1985	
Skilled only	294,000	307,900	4.7
Skilled and intermediate	549,400	724,000	31.8
Intermediate care only	391,600	409,400	4.5
Uncertified facilities	167,400	182,900	9.3
Total	1,402,400	1,624,200	15.8

Source: National Center for Health Statistics. Genevieve Strahan. Nursing Home Characteristics, Preliminary Data From the 1985 National Nursing Home Survey. Advance Data From Vital and Health Statistics. No. 131. DHHS Pub. No. (PHS) 87–1250. March 27, 1987. Table 2. ***and*** National Center for Health Statistics. The National Nursing Home Survey: 1977 Summary for the United States. Vital and Health Statistics: Series 13, Data from the National Health Survey. No. 43. DHEW Pub. No. (PHS) 79–1794. July 1979. Table 1.

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[43] Feder, Judith, and William Scanlon. Regulating the Bed Supply in Nursing Homes. Milbank Memorial Fund Quarterly. 58:1 (1980), p. 54–88. See Congressional Research Service, op.cit., p. 142–3, for an overview of State policies in this area during the 1977–87 period.

One possible response by the industry could have been to build facilities for the private market only, accepting the fact that failure to obtain State approval would permanently foreclose Medicare and Medicaid reimbursement. However, because of the risk that almost any patient could remain in the home long enough to exhaust his or her resources and qualify for Medicaid, relatively few facilities have adopted this approach. As table G–17 indicates, the count of beds in facilities entirely uncertified for Medicare and Medicaid grew much more slowly in the 1977–85 period than the overall bed supply.

However, nursing homes could choose to limit the extent of their Medicare and Medicaid participation. In order to ensure that constraints on bed supply did not disproportionately impact one segment of the aged population, some States required applicants for certificates of need to agree that a certain proportion of their beds would be certified for Medicare and/or Medicaid. These agreements did not constitute a promise to accept a given number of Medicare or Medicaid patients. Moreover, in some States the number of certified beds approved in an application constituted a maximum, not a minimum. A facility could not obtain Medicaid reimbursement for more than a specified percentage of its patients.

As table G–18 indicates, the National Nursing Home Survey found that 17 percent of all nursing home beds were not certified for Medicaid in 1985. This included 6.5 percent of the beds in facilities meeting Medicaid or Medicare certification standards.

Table G–18.—MEDICAID CERTIFIED BEDS, 1985

	Total beds	Beds certified for Medicaid	Percent certified
Facilities with Medicaid or Medicare certification:			
Facilities with both ICF and SNF beds:			
ICF Medicaid certified, SNF Medicare only	6,001	3,718	62.0
ICF and SNF Medicaid certified, no Medicare	178,263	173,550	97.4
ICF Medicaid, SNF both Medicaid and Medicare	522,054	491,555	94.2
Facilities with SNF beds only:			
Both Medicaid and Medicare certified	218,139	214,279	98.2
Medicare certified only	43,543	0	0.0
Medicaid certified only	37,986	37,892	99.8
Facilities with ICF beds only, Medicaid certified	406,651	399,341	98.2
Subtotal, Medicare or Medicaid-certified facilities	1,412,637	1,320,335	93.5
Facilities with no Medicaid or Medicare certification	178,959	0	0.0
Total	1,591,596	1,320,335	83.0

Note: Bed counts for 1985 on the public use data tapes are slightly less than the published values reported in Table G–17 because bed counts for hospitals with more than 300 beds are reported as 300 beds in order to ensure confidentiality.

Source: Congressional Research Service analysis of National Nursing Home Survey data, 1985.

Of the 271,361 uncertified beds, 178,959, or 66 percent, were in facilities no part of which was certified for either Medicare or Medicaid. Many of these beds may have been in facilities which did not provide the level of medical care required to meet certification standards. The uncertified facilities tended to be small ones, with an average of 39 beds, as compared to an average of 99 beds in certified facilities. In addition, the survey included some number of facilities classified as furnishing "domiciliary care," essentially room, board, and nonmedical personal care services. However, the figure probably also includes beds in facilities that could have met certification standards but elected not to participate in Medicare and Medicaid. A comparison of the nursing staffing patterns in certified and uncertified facilities would suggest that the uncertified category includes a mix of homes providing intensive services and homes providing little or no nursing care. (Uncertified facilities have on average the same ratio of registered nurses to patients as certified ICFs, but a much lower proportion of supporting nursing staff.)

Another 43,543 of the beds unavailable to Medicaid patients, or 16 percent, were SNF beds certified for Medicare. Medicare and Medicaid standards for SNFs are identical, and the certifications for both programs are performed by a single State agency. The failure of the facilities to obtain Medicaid certification for the Medicare-certified beds would presumably indicate a decision not to participate in Medicaid.[44] The remaining unavailable beds, 18 percent, are in facilities that have obtained Medicaid certification for some of their beds but not for all of them. This could mean either that a portion of a facility, perhaps a wing or a floor, could not meet certification standards, or that a facility had decided to limit the proportion of beds that would be open to Medicaid patients. The latter may be more likely, since a part of a facility that could not meet Medicaid standards would also be unattractive to the private market.

C. Medicaid Nursing Home Reimbursement

In general, Medicaid nursing home rates are lower than the rates charged to self-pay patients or to Medicare. Table G–19 shows the average basic per diem rates for nursing home care reported by respondents to the National Nursing Home Survey (NNHS) in 1985. The average Medicaid rate for SNF care was 80 percent of the average Medicare rate, and 82 percent of the average private pay rate. For ICF care, the Medicaid average was 82 percent of the private pay average. (The NNHS data do not permit a similar comparison at the individual State level. Table G–20 shows the Medicaid rates alone, as reported by States in a 1986 HCFA survey.)

Table G–19.—AVERAGE BASIC PER DIEM RATES FOR NURSING HOME CARE, 1985

Payer	Skilled nursing facilities	Intermediate care facilities
Private payer	$61.01	$48.09
Medicare	62.02	not covered
Medicaid	49.93	39.57

Source: National Center for Health Statistics. Genevieve Strahan. Nursing Home Characteristics, Preliminary Data From the 1985 National Nursing Home Survey. Advance Data From Vital and Health Statistics. No. 131. DHHS Pub. No. (PHS) 87–1250. March 27, 1987.

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[44] Note that for some SNFs the situation is reversed; 37,986 beds are in facilities certified for Medicaid but not for Medicare.

Table G–20.—AVERAGE RATES PER PATIENT DAY FOR SNFs AND ICFs, FISCAL YEAR 1985

State	SNFs	ICFs
Alabama	$44.29	$30.70
Alaska	N/A	N/A
Arkansas	30.31	28.75
California	46.56	36.70
Colorado	38.54	38.54
Connecticut	60.37	44.58
Delaware	48.94	48.94
District of Columbia	N/A	N/A
Florida	44.29	44.29
Georgia	32.44	30.87
Hawaii	110.90	100.63
Idaho	42.02	41.30
Illinois	38.56	32.54
Indiana	54.94	43.51
Iowa	85.06	29.44
Kansas	39.52	32.13
Kentucky	48.28	33.76
Louisiana	36.55	31.24
Maine	66.46	49.64
Maryland	51.72	51.72
Massachusetts	58.09	41.07
Michigan	40.28	40.28
Minnesota	57.83	42.92
Mississippi	33.51	31.76
Missouri	43.93	38.86
Montana	43.80	43.80
Nebraska	56.48	30.49
Nevada	56.94	51.05
New Hampshire	N/A	N/A
New Jersey	62.25	56.49
New Mexico	82.04	43.11
New York	92.90	61.18
North Carolina	53.34	38.73
North Dakota	51.91	37.25
Ohio	46.54	40.62
Oklahoma	N/A	N/A
Oregon	58.02	37.31
Pennsylvania	44.96	38.24
Rhode Island	53.05	49.07
South Carolina	41.34	41.34
South Dakota	38.40	33.76
Tennessee	47.35	32.67
Texas	41.16	30.73
Utah	47.38	39.15
Vermont	48.61	48.62
Virginia	N/A	N/A
Washington	44.61	44.61
West Virginia	63.98	42.93
Wisconsin	50.09	39.97
Wyoming	49.14	49.14
Simple Average	51.73	41.65

N/A: Data not reported or not available.

Source: U.S. Department of Health and Human Services. Health Care Financing Administration. Analysis of State Medicaid Program Characteristics, 1986. Aug. 1987. Tables 47, 49, 51.

A comparison between overall average private, Medicare, and Medicaid rates may be deceptive, because not all facilities participated in Medicaid. The facilities that did participate, and therefore could report a Medicaid rate, might have had lower private pay or Medicare rates than the average for their class. (If this were the case, a higher likelihood that lower-priced facilities will participate in Medicaid would itself be significant.)[45]

The appropriate comparison, then, is not between national average rates for Medicaid and other payers, but between the Medicaid rate and other rates at each individual facility. As with other kinds of providers, the Medicaid/Medicare or Medicaid/private differential at each facility is likely to be an important determinant of participation.[46]

Tables G–21 and G–22 compare, by facility, 1985 Medicaid daily rates with the rates paid by Medicare for SNF services and by private payers for ICF services. The comparison is confined to ICFs whose private rate was from $45 to $49.99, and SNFs whose Medicare rate was from $55 to $59.99. These ranges were chosen because rates at these levels were those most commonly reported by facilities included in the NNHS. (It should be noted that the NNHS rate data are in $5 ranges. This means, for example, that a Medicaid rate reported as $50–$54.99 and a Medicare rate reported as $55–$59.99 might actually be as little as one cent or as much as $9.99 apart.)

Table G–21.—MEDICAID PER DIEM PAYMENT RATES, INTERMEDIATE CARE FACILITIES WITH PRIVATE PER DIEM RATE OF $45 to $49.99, 1985

Basic Medicaid rate	Percent of facilities	Cumulative percent of facilities
Under $30	2.2	2.2
$30 to $34.99	21.1	23.3
$35 to $39.99	25.2	48.5
$40 to $44.99	29.1	77.6
$45 to $49.99	22.4	100.0

Source: Congressional Research Service analysis of National Nursing Home Survey, 1985.

Among the ICFs whose private rate was $45 to $49.99, 52 percent reported a Medicaid rate of $40 or more, and 22 percent reported a rate in the same $45 to $49.99 range as their private rate. However, 23 percent of the ICFs reported a Medicaid rate of under $35 a day, at least $10 below their private rate.

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[45] Nursing homes with a high proportion of Medicaid patients have been shown to have lower costs and to be more likely to adopt a variety of cost containment measures than other homes. Smith, Howard L., and Myron D. Fottler. Costs and Cost Containment in Nursing Homes. Health Services Research, 16:1 (Spring 1981), p. 17–41. It is not clear to what extent these measures might affect their private pay rates.

[46] A second important determinant, which cannot be investigated with available data, is location. As with physicians or hospitals, a nursing home located in an area with a high number of Medicaid beneficiaries might be expected to accept more Medicaid patients.

Table G-22.—MEDICAID PER DIEM PAYMENT RATES, SKILLED NURSING FACILITIES WITH MEDICARE PER DIEM OF $55 to $59.99, 1985

Basic Medicaid rate	Percent of facilities	Cumulative percent of facilities [1]
Under $30	1.7	1.7
$30 to $39.99	11.2	12.9
$40 to $49.99	42.7	55.6
$50 to $54.99	14.4	70.0
$55 to $59.99	15.4	85.4
$60 to $64.99	7.2	92.6
$65 and over	7.4	100.0

[1] Omits Medicare facilities reporting no Medicaid rate.

Source: Congressional Research Service analysis of National Nursing Home Survey, 1985.

Among the SNFs whose Medicare rate was $55 to $59.99, 12 percent reported a Medicaid rate below $40, and another 40 percent reported a rate below $50. Nearly 15 percent of the facilities reported a per diem Medicaid rate higher than the Medicare rate. This might occur in States that include all ancillary services (such as prescription drugs) in the Medicaid base rate; the comparable Medicare rate excludes these services.

Overall, the comparison suggests that Medicaid reimbursement is more nearly competitive with that of other payers at the ICF level and is generally not as competitive at the SNF level.

D. Summarizing the Trends

In a 1980 article, William J. Scanlon offered an economic model for nursing home participation in Medicaid.[47] The basic outlines of this model are as follows.

The combined Medicaid and non-Medicaid demand for nursing home services exceeds the supply. In this market, patients able to pay the full price for services will be able to obtain all the care they desire. Medicaid beneficiaries are less desirable because of price constraints, and must compete for the beds left over by other patients. In this situation, nursing homes will be in a position to select the Medicaid patients they wish to serve. If the State pays a flat rate for nursing home care, regardless of the specific services required by particular patients, nursing homes will select the patients requiring the least intensive services. Meanwhile the patients most in need of care will be unable to obtain it.

The situation predicted by the Scanlon model fits very closely with the perceptions of Medicaid administrators, discussed earlier, that Medicaid patients are difficult to place and that placement is hardest for heavy care patients. How well does it accord with the actual trend data cited above? The preconditions for Medicaid placement problems—limited bed supply and low Medicaid reimbursement—are clearly present. The supply of nursing home beds has grown more slowly than the population over age 65 and much more slowly than the population over age 85. Of the beds that do exist, one in six is completely unavailable to Medicaid beneficiaries. At the same time, Medicaid reimbursement rates were at least $5 per day below those offered by other payers in a quarter of the ICFs and half the SNFs.

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[47] Scanlon, William J., A Theory of the Nursing Home Market. Inquiry 17:25–41 (Spring 1980).

The trends in Medicaid utilization are more ambiguous. Between 1977 and 1985, the number of current Medicaid nursing home residents grew faster than the supply of beds, but only because each beneficiary served was remaining longer. The number of Medicaid beneficiaries receiving nursing home services over the course of a year grew hardly at all between 1977 and 1985; the number receiving SNF services actually declined. Although these data are suggestive, they do not in themselves confirm the view that limited bed supply and low reimbursement have led to systematic exclusion of Medicaid beneficiaries from nursing homes on a national basis.

That national utilization data do not indicate uniform barriers to Medicaid nursing home admission is not necessarily surprising. The problems could be highly localized, stemming from bed shortages in particular areas or disincentives in particular States' reimbursement policies, without affecting national trends. The major gap in the data is the absence of information on the Medicaid population at the individual facility level, of the sort presented for hospitals earlier in this appendix. (The sampling methodology of the National Nursing Home Survey does not yield information on the patient breakdown of specific facilities.) In the absence of this data, it cannot be known whether Medicaid patients are spread more or less equally across all facilities, or whether there are particular access problems at some facilities and not at others.

E. Restrictive Admission or Retention Policies

In the absence of clear statistical support, claims that some nursing homes exclude or selectively admit Medicaid beneficiaries must rely chiefly on anecdotal evidence. Reports of preferential treatment of private pay applicants for nursing home admission have come, not only from Medicaid officials, but also from State ombudsmen, advocacy groups, and other sources.[48] While these reports do not permit any estimate of the full prevalence of preferential admission practices, they do indicate that many nursing homes have taken steps to limit their Medicaid patient counts. Nursing home industry spokesmen have acknowledged that facilities do attempt to limit their Medicaid caseloads; they argue that these practices are an economic necessity because Medicaid reimbursement is insufficient to cover the costs of adequate nursing home care.[49]

If a nursing home seeks to avoid treating Medicaid patients, its task is more complex than that faced by some other kinds of providers. For example, a patient seeking care from a physician is either a Medicaid beneficiary or not. The provider can predict the potential revenue from the patient and decide whether to grant or withhold treatment.

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[48] A useful summary of reports of preferential admissions practices appears in U.S. General Accounting Office. Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly. Report to the Chairman of the Subcommittee on Health and the Environment, House Committee on Energy and Commerce. October 21, 1983. [GAO/IPE-84-1] p. 107-110.

[49] See, for example, testimony by Dr. Paul Willging, deputy executive vice president, American Health Care Association, before the Senate Special Committee on Aging. Discrimination against the Poor and Disabled in Nursing Homes. Hearings. 98th Congress, 2nd Session. October 1, 1984. [S. Hrg. 98-1091] p. 44-65.

Many non-Medicaid patients entering nursing homes will, if they remain long enough, exhaust their resources or other insurance and become eligible for Medicaid. Even if a patient is still contributing to the cost of his or her own care, if Medicaid is paying any share of the patient's costs the entire cost of the care must then be charged at Medicaid rates. If the nursing home finds Medicaid payment unacceptable, it must consider, not only the patient's status at the time of admission, but the likelihood that the patient will convert to Medicaid and the time likely to elapse before the patient does so.

As a result, some nursing homes have been reported to have adopted a variety of practices intended, not only to exclude new Medicaid admissions, but also to prevent or delay the conversion of an existing private pay patient to Medicaid status, expel an existing patient who converts to Medicaid, or make up the revenue loss resulting from the conversion. Some of these practices, especially those relating to the treatment of existing patients, have long been prohibited under Federal law or regulations. The nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203, OBRA87) will strengthen some of these rules and their enforcement, effective in 1990.

Nursing homes in most States may still refuse admission to a new patient who is already eligible for Medicaid or who is deemed likely to convert to Medicaid in a short time. The OBRA87 provisions place some limitations on nursing home admission practices, but do not explicitly require a policy of nondiscrimination.

The rules on admission or retention of patients apply only to a facility that chooses to participate in Medicaid or Medicare. A home that absolutely declines public reimbursement for any patient, refusing Medicaid even if a patient exhausts his or her resources, is not subject to any nondiscrimination rules. (The approximately 500 nursing facilities constructed with Federal funds under the Hill-Burton Act of 1946 must agree to participate in Medicaid.)

1. PROHIBITED PRACTICES RELATING TO EXISTING PATIENTS

Expulsion of patients. The simplest way of preventing private patients from converting to Medicaid is simply to discharge any patient who is no longer able to pay for his or her own care. This practice is prohibited under Federal regulations and, effective October 1, 1990, under the statute as well. As a condition of participation in Medicaid and Medicare, a nursing home must agree that it will transfer or discharge patients only for medical reasons, to protect the patient's welfare or that of other patients, or for nonpayment. Conversion to Medicaid status does not count as "nonpayment." [50]

A related practice that has sometimes been reported is to transfer a Medicaid patient to a hospital on the grounds that the patient is temporarily in need of acute care. During the patient's absence, a private pay patient can be admitted. When the Medicaid patient is ready to return to the home, there may be no space. Transfer without a valid medical reason is prohibited by the regulations cited above. If the transfer is valid, however, there is presently no requirement that a facility hold the vacant bed open. Most States will continue payment to a nursing home for a fixed number of days in order to reserve the bed. After October 1, 1990, a nursing home will be required to keep a bed open as the long as the State continues payment. If the patient is necessarily absent for longer than the State's maximum bed reservation period, the home will be permitted to admit another patient, but will have to make the next available bed available to the patient waiting to return. (Not all States provide bed reservation periods.)

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[50] A nursing home may transfer or discharge a patient who loses Medicaid eligibility and is unable to pay for his or her care. This might occur if a patient is found to have transferred assets prior to applying for Medicaid and is therefore disqualified from receiving Medicaid for a specified period. See Chapter II for a discussion of the transfer of asset rules.

Supplementation. Some homes have asked patients' relatives to make up the difference between the Medicaid payment and the private charges. This practice, known as supplementation, is a Federal crime and is also subject to civil monetary penalties under the OBRA87 changes.

Private pay contracts. Some homes have required new patients, or their relatives, to sign "private pay contracts" at the time of admission. Typically, the patient agrees not to apply for Medicaid benefits for a fixed period, such as 12 or 18 months, regardless of whether the patient becomes eligible for Medicaid during that period. A relative or other guarantor promises to continue payment at the nursing home's private rate until the end of the contractual period. At that point the patient may apply for Medicaid and the home will accept Medicaid payment. Some private pay contracts have been "duration of stay" agreements, under which the patient agrees never to apply for Medicaid benefits.

Unlike some of the other practices described, the use of private pay contracts has been widespread and open. HCFA and some States have taken the position that such contracts are prohibited by a provision of the Act barring the acceptance of money or other consideration as a precondition of admission or continued stay. Nursing homes have contended that this provision bars supplementation, but not private pay contracts, and the matter has been the subject of ongoing litigation. OBRA87 provides, effective October 1, 1990, that a nursing home may not require a potential patient to waive the right to apply for Medicaid, and may not require any form of payment guarantee by a third party. A home may still require a relative who controls a patient's funds to make payment from those funds.

Partial certification. As was noted above, some Medicaid-certified facilities have obtained certification for some, but not all, beds in the facility. The certified and uncertified beds may or may not be physically distinct; in homes without specific Medicaid beds, the count of certified beds is essentially a limit on the number of Medicaid patients the facility will accept. Some homes have taken the position that a private pay patient may convert to Medicaid status only if there is a certified bed available; the patient may be discharged if the home has reached its Medicaid limit. This practice is prohibited by the general bar on nonmedical discharges cited above. However, homes that do physically distinguish between

Medicaid and non-Medicaid beds may transfer a patient to another part of the facility once the patient qualifies for Medicaid.

2. PRACTICES RELATING TO NEW PATIENTS

In most States, nursing homes may simply decline to admit applicants who are already Medicaid beneficiaries or whose financial resources are so limited that they appear likely to qualify for Medicaid after entering the facility. OBRA87 provides that, effective October 1, 1990, a nursing facility may not "require oral or written assurance that [individuals applying to reside or residing in the facility] are not eligible for, or will not apply for, benefits" under Medicaid or Medicare. This provision prohibits a facility from requiring an applicant to waive any present or future claim for Medicare or Medicaid benefits (such waivers have sometimes been a part of private pay contracts). Facilities may still assess an applicant's financial status and base an admission decision on this assessment. In short, refusal to admit Medicaid beneficiaries remains permissible under Federal law.

Some facilities may decline to admit a Medicaid beneficiary on the grounds that, although a vacant bed exists, it is not a Medicaid-certified bed. Partial certification allows a facility to set an upper limit on the number of Medicaid patients it will accept. In March 1988, a Federal magistrate in Tennessee recommended to the U.S. District Court that the practice of partial Medicaid certification be prohibited on the grounds that it disproportionately affects the ability of minorities to obtain access to nursing homes. The magistrate's conclusion was that, since minorities account for a high percentage of Medicaid beneficiaries, admission practices that discriminated against Medicaid beneficiaries discriminated against minorities and were prohibited under the Title VI of the Civil Rights Act of 1964. (A nursing home would be subject to the Act if it accepted any Medicaid or other Federal funding.)[51] The equation of economic and racial discrimination, if upheld, could affect other selective admissions policies in areas where minorities constitute a large share of Medicaid enrollment.

3. STATE RESPONSES

Some States have taken steps to prohibit discrimination against Medicaid beneficiaries or to modify the financial incentives promoting such discrimination.

Minnesota's approach has been to provide that, if a home accepts Medicaid at all, it may not charge its private patients more than the rate approved by Medicaid. Under this system, the home has no incentive to give preferential treatment to private-pay patients. North Dakota is in the process of implementing a similar system.

New Jersey has, over time, adopted several different solutions to alleviate what have been reported to be especially serious access problems. Its first approach was to require applicants for a certificate of need to guarantee that a new facility would be operated with an open admissions policy. More recently, New Jersey has required any home that participates in Medicaid at all to have an open admission policy if its percentage of Medicaid patients is below a fixed target level. So long as the Medicaid percentage is below 45 percent, the home may not discriminate in new admissions. (The effect of such a policy may be limited if a home is able to meet the 45 percent target through the gradual conversion of private-pay patients to Medicaid.)

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[51] *Linton* v. *Commissioner of Health and Environment Department, State of Tennessee,* No. 3:87-0941 (M.D. Tenn., March 18, 1988), as reported in Nursing Home Law Letter Issue 115 (June 1, 1988).

Oregon has addressed the issue of partial certification, the practice in some facilities of establishing explicit limits on the number of Medicaid patients they will accept. Except for facilities that are phasing out of the Medicaid program (accepting no new Medicaid patients but retaining those currently resident), a facility may not declare any of its beds closed to Medicaid beneficiaries.

Finally, States may flatly prohibit discrimination by payment source. Connecticut and Maine require facilities to maintain a single, uniform waiting list for all applicants for admission. A facility with an opening must accept the next patient on its list, regardless of payment source.

4. CASE MIX SYSTEMS

As was noted earlier, a number of States have reported that only patients requiring the most intensive services are difficult to place. Facilities may be prepared to accept Medicaid patients, but are not prepared to accept those requiring "heavy care." [52] Some people have argued that refusal to admit more severely disabled patients amounts to discrimination against the handicapped and is therefore prohibited by section 504 of the Civil Rights Act. Nursing facilities may respond that they are not discriminating, but are simply not equipped to handle certain kinds of physical or mental problems. As the Scanlon model suggests, if a Medicaid program pays a uniform rate for all patients in a facility, regardless of their condition, the facility has an incentive to select the lightest care patients.

In response to this problem, a number of States have adopted "case mix" reimbursement systems, which involve adjustment of rates to reflect the level of services required by individual patients. Others make supplementary payments, over and above the daily reimbursement rate, to cover specific services required by severely disabled patients. (See chapter IV for a further discussion of these systems.)

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[52] Particular problems have been reported in placing patients suffering from dementia. They may not have the physical problems necessary to qualify for Medicare SNF reimbursement, but may nevertheless require constant attendance. Hawes and Phillips, op.cit.

APPENDIX H. MEDICAID AND AIDS [1]

I. INTRODUCTION

Medicaid has emerged as an important source of coverage for persons with acquired immunodeficiency syndrome (AIDS). Current estimates suggest that as many as 40 percent of all AIDS patients become eligible for Medicaid benefits at some point in the course of their illness. Medicaid's share of total costs for these patients is somewhat lower, perhaps in the range of 20 to 30 percent, because some persons with AIDS qualify for Medicaid only after having been ill for some time. Medicaid's role in financing health services for persons with AIDS may expand in the future, both because of changes in the nature of the population developing AIDS and because other forms of insurance coverage may become less available to persons with AIDS.

This appendix is in two parts. The first explores why Medicaid is covering such a large proportion of the AIDS caseload, reviews projections of the dollar impact, and discusses prospects for the future. The second examines issues relating to Medicaid coverage of specific services needed by persons with AIDS.

II. THE POTENTIAL IMPACT OF AIDS ON THE MEDICAID PROGRAM

A. CURRENT ESTIMATES

1. SCOPE OF THE EPIDEMIC

AIDS was first reported in the United States in 1981. As of August 1, 1988, 69,366 cases of AIDS had been reported to the Centers for Disease Control (CDC); 56 percent of these persons had died. CDC has estimated that as many as 1.5 million Americans could be infected with the human immunodeficiency virus (HIV), which causes AIDS. Although it is still not certain how many of these will develop AIDS, CDC projects that at least 270,000 cases will have been diagnosed by the end of 1991, and 450,000 by 1993. Many more infected persons will develop symptoms of AIDS-related complex (ARC); some of these people will be just as ill as those officially categorized as having AIDS.[2]

These projections are highly tentative: there is no reliable information about the size of the two major populations at risk, gay and bisexual men and intravenous (IV) drug abusers and their sexual partners, and there are varying estimates of the prevalence of infection among members of risk groups.

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[1] This chapter was written by Mark Merlis.

[2] The term "AIDS" is officially used by CDC only for HIV-infected persons who develop certain specific problems, such as pneumocystis pneumonia, Kaposi's sarcoma (a form of skin cancer), or central nervous system deterioration. Persons who develop other problems not on the official list may be classified as having ARC. The Institute of Medicine and other observers have suggested that the distinction is artificial and should be abandoned.

2. HEALTH CARE COSTS

Estimates of health care expenditures for a typical patient from diagnosis to death have ranged from $24,000 to $147,000; most estimates have been in the $25,000 to $35,000 range. A 1986 CDC report, using a somewhat higher per capita cost estimate, projected total calendar 1991 costs of between $8 and $16 billion.[3] More recent estimates, using higher case load projections but assuming lower per capita cost, have tended towards the lower end of this range. It is also unclear how the development of new treatments for AIDS might affect costs. The drug zidovudine (formerly known as AZT) costs an average of $7,000 to $10,000 per patient per year. These costs might or might not be offset in any given year by savings from reduced hospitalization.

3. MEDICAID SHARE OF HEALTH CARE COSTS

In addition to the uncertainties about overall costs, there are differing estimates of the shares of those costs borne by public and private payers. Most early studies found that Medicaid was covering 20 to 30 percent of the total costs of AIDS treatment, compared to the 40 to 60 percent of total costs covered by private health insurance.[4] Medicaid's share of the total patients may be higher than its share of expenditures, perhaps 40 percent. There are several possible reasons for this. Some patients may qualify for Medicaid after already having received some treatment. They may receive different services from those used by patients with other sources of coverage, or Medicaid may not cover the entire cost of their services.

More recent studies have suggested that Medicaid's share of total costs may be rising, while the share paid by private insurance is dropping. Whether this represents a real shift from private to public financing, or merely a difference in the populations being studied, is not clear.

The largest study of AIDS treatment costs to date, a survey of 169 public and teaching hospitals, found that Medicaid covered 54 percent of the AIDS patients treated by these hospitals in 1985, while private insurance covered only 17 percent.[5] However, these hospitals treated only about a third of all AIDS patients. As discussed in Appendix G, public and teaching hospitals tend to serve a disproportionate share of Medicaid patients. The patients at the hospitals surveyed may therefore not have been representative of the total population with AIDS. (The sponsors of the study are now conducting a broader survey that will also include other kinds of hospitals.)

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[3] Coolfront report: a PHS plan for prevention and control of AIDS and the AIDS virus. Public Health Reports, 101:4 (Jul.-Aug. 1986), 341-48. No published cost estimates beyond 1991 were available as of June 1988.

[4] For a review of these studies, see The costs of AIDS and other HIV infections: Review of the estimates. Staff paper, Office of Technology Assessment. Washington. 1987.

[5] Andrulis, Dennis P., et al. The provision and financing of medical care for AIDS patients in US public and private teaching hospitals. Journal of the American Medical Association, 258:10 (Sep. 11, 1987), p. 1343-46.

Still, it is possible that the Medicaid share of the AIDS caseload has been growing and will grow in the future, for a number of reasons. In order to understand these trends, it is first necessary to review how persons with AIDS become eligible for Medicaid benefits.

B. MEDICAID ELIGIBILITY FOR PERSONS WITH AIDS

Persons with AIDS may qualify for Medicaid in one of three ways. They may be eligible for Supplemental Security Income (SSI) disability payments or may qualify as medically needy for reasons specifically related to their illness, or they may qualify for economic reasons unrelated to their illness.

1. SSI DISABILITY

Persons with AIDS may qualify for Supplemental Security Income (SSI) disability benefits under an expedited process, and will then be automatically eligible for Medicaid in most States. In order to receive SSI, a disabled person must meet income and resource standards, must not be engaged in substantial gainful activity, and must be determined by a physician to meet medical standards of disability. As a result of a Social Security Administration ruling, persons with a confirmed diagnosis of AIDS are presumed to have met the disability standard. They must still meet the other two criteria, but they may qualify for benefits more rapidly than other applicants, whose medical disability must be determined on an individual basis. Persons with AIDS-related complex (ARC), who may sometimes be just as ill as persons with AIDS but who do not meet the strict definition of AIDS established by the Centers for Disease Control (CDC), are not presumed to be disabled. They may still qualify for SSI on an individual basis by going through a standard SSI medical review process.

2. MEDICALLY NEEDY

As of October 1986, disabled persons could qualify as medically needy in 29 States.[6] Medically needy disabled persons do not meet the income standards for SSI, and therefore do not receive cash assistance, but do meet the other criteria for SSI eligibility. They may receive Medicaid if they meet the State's asset limits and if their net income, after subtracting incurred medical expenses and certain other disregarded amounts, is below a medically needy standard established by the State. Some persons with AIDS or ARC who lack other insurance coverage may "spend-down" to Medicaid eligibility by incurring large medical bills.

One group of persons with AIDS that may be especially likely to qualify as medically needy are those who are receiving Social Security disability insurance (SSDI) payments but have not yet become eligible for Medicare benefits. Recipients of SSDI benefits may receive Medicare only after completing a 24-month waiting period. Because this is longer than the average life span after diagnosis, few SSDI recipients with AIDS ever receive Medicare benefits. Estimates are that Medicare covers no more than 1 to 3 percent of total costs for the treatment of AIDS. As new life-sustaining treatments are introduced, it is possible that a larger number of persons with AIDS will survive to qualify for Medicare benefits. For these persons, Medicaid may then serve as an interim source of coverage, carrying beneficiaries to the end of their Medicare waiting period. In States without medically needy programs, however, SSDI recipients whose incomes are too high to meet SSI cash assistance standards may be left with no coverage at all during that period.

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[6] Another 10 States had medically needy programs that did not include the disabled. Health Care Financing Administration. Analysis of State Medicaid Program Characteristics, 1986. Baltimore. 1987. p. 27.

3. LOW INCOME PERSONS WITH AIDS

Some persons with AIDS are already eligible for Medicaid at the time they become ill. This may be especially true of intravenous (IV) drug users and their sexual partners and children, who are likely to have low incomes and who may have qualified for SSI or for Aid to Families with Dependent Children (AFDC) prior to developing AIDS.

The proportion of persons with AIDS who qualify for Medicaid in a particular State may depend on the State's Medicaid coverage policies and also on the nature of the AIDS population in that State. The survey of public and teaching hospitals cited earlier found significant regional variation in the percentages of persons with AIDS covered by Medicaid. In the Northeast, 60 percent of AIDS patients treated in 1985 were Medicaid-eligible at the time of admission, while 19 percent had no public or private insurance. The situation was reversed in the South. Hospitals there reported that Medicaid covered only 15 percent of all AIDS admissions, while 54 percent were uninsured. The authors suggest that the major reason for the disparity is that Medicaid programs in many southern States have more restrictive eligibility standards than those elsewhere; they are, for example, least likely to offer medically needy coverage. Another factor may also play a part. Many more of the cases in the Northeast were related to IV drug use: 53 percent, as compared to 17 percent in the South. As was suggested earlier, IV drug users and their partners and children may be more likely to be eligible for Medicaid prior to the onset of the disease.

C. Future Trends

Several trends could potentially affect the role of Medicaid in financing care for persons with AIDS.

First, there is evidence that the disease is now spreading more rapidly among IV drug users and their sexual partners, and less rapidly among gay and bisexual men. This means that an increasing proportion of AIDS cases may be among the low-income persons most likely to qualify for Medicaid before developing AIDS. As was noted earlier, Medicaid's share of total AIDS expenditures is believed to have been less than its share of the AIDS patient population, in part because many persons have qualified for Medicaid after being diagnosed and after having incurred medical expenses. If more patients qualify for Medicaid prior to the onset of the disease, Medicaid will be covering these patients' costs for the entire course of the illness. The demographic shift in the AIDS population could mean, not only that Medicaid will cover a larger portion of the population, but also that Medicaid expenditures for each patient covered will increase.

Second, it may become increasingly difficult for persons infected with the AIDS virus to obtain private health insurance coverage. A recent Office of Technology Assessment survey of commercial insurers, Blue Cross/Blue Shield plans, and health maintenance organizations found that a majority of all three types of insurers were screening out or restricting coverage for persons with AIDS or persons infected with the AIDS virus who applied for individual health insurance coverage.[7] These policies would not generally affect persons obtaining coverage through their employment; ordinarily, all members of an employer group are automatically eligible for the employer's health benefit program. Individual screening may occur in very small firms, however, and there are anecdotal reports that some employers may be excluding persons with AIDS from their health plans or even dismissing them in order to avoid cost increases in the health benefit program.[8] These trends could mean that more persons with AIDS will be left to pay their own health care costs and may be more likely to qualify for Medicaid through the spend-down process.

Third, as noted earlier, new treatments could prolong the lives of some persons with AIDS while leaving them exposed to large medical expenses. Again, this could mean that a larger number of persons with AIDS would become eligible by depleting their assets and qualifying as medically needy through the spend-down process.

Even if none of these changes were to occur, and assuming that Medicaid expenditures for beneficiaries with AIDS keep pace with overall costs for AIDS health care, a low estimate of Medicaid AIDS costs for 1991 would be $2 billion (25 percent of the low-range $8 billion total for AIDS health care). This would amount to about 3 percent of total Medicaid expenditures in that year. A recent Rand Corporation study for HCFA offered an "intermediate" estimate in the same range for the 1986–91 period. However, using more pessimistic assumptions about the spread of the disease and Medicaid's share in the costs, the study offered a "high" estimate that AIDS would account for $47 billion in Medicaid expenditures in those years. Under this scenario, 13 percent of Medicaid expenditures would go to services for AIDS, or more than the total amount being spent for services to dependent children.[9]

Whatever the impact of AIDS on Medicaid costs, it will be felt disproportionately in a few States. While the caseload is beginning to grow in other areas, over the short term the AIDS population will continue to be concentrated in the original centers of infection, such as New York and California. If costs continue to grow at present rates, payments for AIDS patients could account for at least 5 percent to 6 percent of total Medicaid expenditures in those

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[7] U.S. Congress. Office of Technology Assessment. AIDS and health insurance: An OTA survey. Washington. 1988. p. 3.

[8] Oppenheimer, Gerald M., and Robert A. Padgug. AIDS: The risks to insurers, the threat to equity. Hastings Center Report, v. 14 (October 1986), p. 18–22.

[9] Pascal, Anthony. The costs of treating AIDS under Medicaid: 1986–91. Santa Monica. 1987 [Rand Note no. N-2600-HCFA] p. vi.

States by fiscal year 1991. A potential result could be pressure to curtail services to other kinds of Medicaid beneficiaries.

III. MEDICAID COVERAGE OF SERVICES FOR BENEFICIARIES WITH AIDS

Persons with AIDS may suffer from any of a wide variety of "opportunistic infections," diseases that are rare in the general population but that affect persons with AIDS because of their compromised immune systems. In some cases the AIDS virus may also cause central nervous system problems. Because AIDS manifests itself in so many different ways, the course of the disease and the nature of the treatment required vary from patient to patient. Some patients are acutely ill and require continuous hospitalization from the time of diagnosis until death. Others are only intermittently in need of the level of treatment provided by inpatient hospitals; the rest of the time they could remain at home with adequate home health care and support services. Those in the final stages of the disease could benefit from hospice care. Finally, some patients, particularly those with central nervous system problems and resulting dementia, may require care at the nursing home level. The effects of Medicaid coverage and reimbursement policies on the care of individual AIDS patients may vary, depending on those patients' particular needs.

Patients requiring acute care services, such as those of hospitals and physicians, may encounter barriers comparable to those faced by other beneficiaries. In some States, Medicaid coverage of inpatient services is limited to a fixed number of days per patient. In others, payment is made at fixed rates, regardless of costs. Many hospitals have reported that Medicaid reimbursement is inadequate to meet the high costs they incur in treating AIDS patients. Some facilities may respond by referring persons with AIDS to public or teaching hospitals which are prepared to accept Medicaid reimbursement. Payment levels may also affect access to other kinds of services, such as nursing home and hospice care.

In addition, there are some services that State Medicaid programs may not cover. While all States must offer some form of home health care, coverage may be limited and may not include the highly intensive nursing care required by some AIDS patients or the personal care services required by others. Only eight States offer hospice services as a routine benefit. While States might consider adding additional services to meet the needs of persons with AIDS, they may be prevented from doing so by a general Medicaid rule against discrimination by diagnosis. Services provided to beneficiaries must be uniform; new services usually cannot be added just for persons with a particular condition (two exceptions, the "2176" waiver program and the targeted case management option, are discussed below).

Nevertheless, some States have begun to explore ways to improve access to existing services for persons with AIDS or to develop new services. The following is a discussion of some of the more important issues relating to specific services.

A. HOME AND COMMUNITY CARE

At present, most treatment for persons with AIDS occurs in inpatient hospital settings. This is not only costly, but could eventually strain the physical capacity of hospitals in the localities most heavily affected. The alternative to expanding hospital capacity is to find ways of treating more persons with AIDS in other settings. An approach being explored in many localities is the development of comprehensive care systems, combining acute AIDS treatment units with community support services. San Francisco's innovative system, coordinating a specialized inpatient treatment center with a network of outpatient and community services, is reported to have reduced average per patient costs while at the same time providing more humane care.[10] Both the Public Health Service and private sources have supported efforts to develop similar systems elsewhere.

Medicaid programs ordinarily may not reimburse for the nonmedical social and support services that are an integral part of these systems. In addition, although home health care is a mandatory Medicaid benefit, many States offer only limited home health services. They may not cover the intensive services some persons with AIDS may need if they are to remain in the community, such as parenteral (intravenous) nutrition. Again, these coverage policies usually cannot be modified in order to help persons with a particular diagnosis.

A State may obtain an exception to these rules, with the approval of HCFA, through a waiver for the provision of home and community based services. Under a waiver, the State may offer a special package of services to a defined population as an alternative to institutional care. The package may include expanded home health care, case management, and other services needed to help chronically ill beneficiaries remain in community settings. These waivers, known as section 2176 waivers after the provision of the Omnibus Budget Reconciliation Act of 1981 (OBRA81, Public Law 97-35) that created them, are discussed more fully in chapter V.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, COBRA) made technical changes in the waiver authority to make it easier for States to develop programs for persons with AIDS. The changes clarified that a State could establish a waiver program for persons at risk for hospital care; prior to the changes, a program could serve only persons at risk of needing nursing home services. As of February 1988, four States, Hawaii, New Jersey, New Mexico, and Ohio, had taken advantage of the new option. New Jersey's program is targeted at IV drug users, their sexual partners, and children, who have been the major population at risk in that State. The program includes case management, medical day care, home-based drug abuse treatment, and other support services. (Some other States may be serving persons with AIDS under waiver programs targeted at more general populations of the physically disabled.) [11]

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[10] Scitovsky, Anne A., Mary Cline, and Philip R. Lee. Medical care costs of patients with AIDS in San Francisco. Journal of the American Medical Association, 256:22 (Dec. 12, 1986), p. 3103-6.

Under a new option added by COBRA, States may offer case management services to special populations without a waiver. This "targeted" case management option allows a State to improve the coordination of available medical and social services for members of the target group. Unlike the 2176 waiver option, however, the case management option does not allow the State to cover more services for the target group than for other Medicaid beneficiaries.

B. HOSPICE CARE

COBRA authorized States to cover hospice services as an optional Medicaid benefit. As chapter III indicates, eight States had elected to cover hospice services as of August 1987.

Hospices are programs that provide "palliative treatment," care intended to comfort rather than cure, to terminally ill patients. Although some hospices maintain their own facilities, most hospices provide care to patients in their own homes. Under Medicare and Medicaid rules, a hospice is not a facility but a coordinated system for providing intensive home health care, counseling, and related services. Patients are expected to spend most of their time at home, usually with a family member or friend as a routine care-giver. Reimbursement for hospice services furnished on an inpatient basis is strictly limited, and the hospice may be financially penalized if patients are treated on an inpatient basis more than 20 percent of the time. The effect of this rule has been to limit the usefulness of the hospice option as an alternative to hospital care for persons who have AIDS and who are without a stable living situations. The Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203, OBRA87), permits waivers of the inpatient care limitations for Medicaid hospice patients with AIDS.

However, Medicaid hospice payments continue to be subject to overall dollar limits. The average amount paid to a hospice for all the Medicaid beneficiaries treated during a year cannot exceed a fixed cap ($8,403 per patient in 1988). These limits may discourage some private hospices from participating in the program.

C. NURSING HOME CARE

Persons with AIDS requiring the level of services provided by nursing homes have faced continuing problems in obtaining access to care. Some facilities are afraid of potential infection, or may be forbidden by State law to accept patients with infectious diseases. Others may argue that they are simply not equipped to deal with the special needs of some persons with AIDS, particularly those suffering from mental illness or those addicted to drugs. One State, Minnesota, has taken legal action to compel nursing homes to accept persons with AIDS. On a national basis the number of nursing homes accepting AIDS patients remains very small.

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[11] U.S. Department of Health and Human Services. Public Health Service. AIDS: A public health challenge. [Prepared by Intergovernmental Health Policy Project] Washington. 1987. v. 2, p. 6–13

The access barriers faced by persons with AIDS may be compounded if they have no financial resources of their own. As Appendix G indicates, facilities in areas with high nursing home occupancy rates may have incentives to adopt preferential admission policies. They may accept private pay patients before Medicaid patients and, when they accept Medicaid patients, select those requiring the least intensive services. One solution to this problem, adopted by 6 States as of January 1988, is to vary Medicaid payment according to the "case mix" at a particular facility. Facilities receive higher reimbursement if they treat patients requiring more intensive care. Two States, Florida and Wisconsin, have attempted to improve nursing home access by offering higher Medicaid reimbursement specifically for AIDS patients. Once again, different rules for persons with AIDS could potentially conflict with the general Medicaid prohibition against discrimination by diagnosis.

D. DRUGS AND OTHER EXPERIMENTAL THERAPIES

Zidovudine (formerly known as AZT), approved for therapeutic use by the Food and Drug Administration (FDA) in early 1987, has proved effective in the short term in reducing the rate of opportunistic infections among persons with AIDS. The cost of maintaining a patient on zidovudine for a year was originally estimated at $7,000 to $10,000, and there were initial concerns that many patients who might benefit from the drug would be unable to afford it. In response to this problem, Congress provided $30 million in the fiscal year 1987 Supplemental Appropriation Act (Public Law 100–71) for grants to States to assist patients needing zidovudine. As a condition of obtaining the grant funds, any State that covered prescription drugs under its Medicaid program had to add zidovudine to the list of drugs approved for Medicaid reimbursement.

The issue of Medicaid coverage arose in part because 23 States have restrictive "formularies," limited lists of drugs they will cover, which may not include every drug approved for clinical use by the FDA. Although the issue of coverage for zidovudine appears to have been settled, other new AIDS treatments are likely to appear in the near future. The question of when Medicaid programs should extend coverage to new drugs or other therapies can be expected to arise again.

Medicaid programs, like Medicare and other health insurers, will cover only therapies which are proven effective. The insurers' position is that the costs for new, untried technologies are properly research expenditures, not health care. The terminally ill obviously have a different view of the matter, believing that they should have access to any treatment which offers any chance of success, without waiting for it to prove its value.

Some State Medicaid programs have expedited their procedures for approving new AIDS treatments, but none covers treatments which are still regarded by FDA as being in the clinical trial stage. California is developing an independent assessment mechanism which may allow approval of some new treatments prior to FDA action.

E. SPECIAL PROBLEMS OF CHILDREN

As of May 30, 1988, 1,003 cases of AIDS in children under 13 had been reported to the Centers for Disease Control (CDC). In 77 percent of the cases, the child apparently contracted the disease from an infected mother; CDC estimates that 30 percent to 50 percent of children born to infected mothers will also be HIV-infected. How many will actually develop AIDS is uncertain.

Hospitals and social services agencies have reported a growing problem with children who have AIDS or are HIV-infected and who are abandoned by their mothers, or whose mothers are themselves too sick to care for their children. The children sometimes must remain in the hospital, even though they do not require acute care, because no alternative placement can be found. Potential foster parents may be reluctant to accept these children, and there may be concerns about placing possibly infected infants with other children in group homes or shelters. As a result there have been cases in which children have spent their entire lives in hospitals, often at enormous cost. These so-called "boarder babies" include, not only children born with HIV infection, but also children who addicted to drugs at birth because their mothers used drugs during pregnancy.

The Medicare Catastrophic Coverage Act of 1988 (Public Law 100–360) establishes a new home and community-based services waiver program under Medicaid, similar to the section 2176 waivers described earlier but specifically targeted at boarder babies. States could develop special support programs for children up to age 5 who are HIV-infected or addicted to drugs at birth, or who have developed AIDS after birth.

Children would be eligible to participate if they would be likely, in the absence of waivered services, to require the level of care provided by a hospital or nursing facility. Covered services could include nursing care, physicians' services, respite care, prescription drugs, medical devices and supplies, transportation, and any other service requested by the State and approved by the Secretary. Further details on the new section 1915(e) "boarder baby" waivers are provided in chapter V.

ADDENDUM I

SUMMARY OF MAJOR MEDICAID PROVISIONS IN THE FAMILY SUPPORT ACT OF 1988, P.L. 100–485

On October 13, 1988, after the Congressional Research Service had completed its work on this document, the Family Support Act of 1988 was signed into law. This legislation contains a number of important changes in the Medicaid program. The following summary of these changes was prepared by the majority staff of the Subcommittee on Health and the Environment. (For a discussion of current law, see Chapter II, Eligibility, Categorically Needy, Coverage of Families and Children, and Appendix A, Medicaid and the Poor, AFDC Eligibility Categorically Needy Income Limits, and Poverty).

Transitional Medicaid Coverage for Working Poor Families. Effective April 1, 1990, States are required to extend Medicaid coverage for 12 months to families who leave cash assistance due to earnings.

During the first 6 months of coverage, the States must provide each family the same Medicaid coverage that the family had while on cash assistance. States are not permitted to impose premiums for this coverage. States do have a "Medicaid wrap around" option, under which they may use Medicaid funds to pay a family's expenses for premiums, deductibles, and coinsurance for any health care coverage offered by the employer of the caretaker relative. The employer coverage would then be treated by the Medicaid program as a third party liability.

During the second 6 months of coverage, the States have a number of options. First, they could limit the scope of the Medicaid coverage to acute care benefits, dropping nursing home coverage and other nonacute benefits. Second, States could impose a monthly premium on families with incomes, less necessary child care expenses, in excess of 100 percent of the Federal poverty level. The monthly premium on these families could not exceed 3 percent of gross income. Premiums would be determined on the basis of quarterly reports from families on earnings and child care costs. Third, States have the option of offering families the choice of (1) basic Medicaid coverage (either the same as offered to cash assistance beneficiaries or the more limited acute care package) or (2) one or more types of alternative coverage. These alternative coverages could include enrollment, at Medicaid expense, in an employer group health plan, a State employee plan, a State health plan for the uninsured, or a health maintenance organization. Families would always have a choice of staying with their basic Medicaid coverage, although they could not elect both the basic Medicaid and one of the alternative coverages. With respect to the basic Medicaid coverage, States would have the same "Medicaid wrap-around" option as during the first 6 month period. In general, transitional coverage would terminate if a family no longer had a dependent child, failed to report earnings on a quarterly basis, failed to pay any required premium, or fraudulently obtained cash assistance benefits.

This provision will expire after September 30, 1998; at that time, the current law 4-month transitional benefit will be reinstated.

According to estimates of the Congressional Budget Office, this provision will provide Medicaid transitional coverage to approximately 475,000 individuals during the first 6 months, and an estimated 240,000 individuals during the second 6 months when the premium option becomes available to the States.

Coverage of Families with Unemployed Parents. Effective October 1, 1990, States are required to extend cash assistance benefits to two-parent families where the principal earner is unemployed (AFDC–UP). States that have an AFDC–UP program as of September 26, 1988, are required to continue operating such programs without any time limit on eligibility. Other States will have the option to limit cash assistance benefits to as few as 6 months in any 12-month period. States are required to provide full Medicaid coverage to all members of these families even in months when cash assistance benefits are not paid because of a State-established time limit.

This requirement will expire after September 30, 1998; at that time, the current law AFDC–UP provisions will be reinstated.

According to estimates of the Congressional Budget Office, this provision will extend Medicaid coverage to an average of 65,000 families, or 285,000 individuals in each month.

ADDENDUM II

INDEX TO THE MEDICAID STATUTE

Many have remarked on the complexity of the Medicaid statute, which is found in Title XIX of the Social Security Act. In *Schweiker* v. *Gray Panthers,* 453 U.S. 34, 43 (1981), the U.S. Supreme Court, per Mr. Justice Powell, observed that "The Social Security Act is among the most intricate drafted by Congress. Its Byzantine construction, as Judge Friendly has observed, makes the Act almost unintelligible to the uninitiated."

To assist the reader in locating provisions in the Medicaid statute, this addendum contains an index that provides specific section references for a number of commonly used Medicaid terms. No warranties are made that the statutory section, once located, will be intelligible.

This addendum was assembled by the majority staff of the Subcommittee on Health and the Environment and does not represent the work product of the Congressional Research Service. The subcommittee gratefully acknowledges the assistance of Edward G. Grossman of the House Office of Legislative Counsel.

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Requirement	1902(a)(1)
Waiver	1915(a), (b), (c), (d), (e), (g)
Swing Beds	1913; 1902(a)(13)(A)
TPL (Third Party Liability)	1902(a)(25); 1902(g); 1903(o)
Transfer of Assets	1902(a)(18); 1917(c)
Transsitional Medicaid Coverage:	
Working Welfare Families	1902(e)(1); 402(a)(37); 1925 (effective April 1, 1990)
Child or Spousal Support	406(h)
"209(b)" Option	1902(f)
UR (Utilization Review)	1902(a)(3)(A); 1902(d)
Working Disabled	1902(a)(10)(A)(i)(II); 1905(q); 1619
Work Transition Coverage	1902(e)(1); 402(a)(37)
Wrap Around	1925(a)(4)(B), (b)(4)(C)

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